

Dr. Swapna

# ESTIMATION SLIP

Date : 2/6/26 UHID / IP No. : BAH-00520821 SI No. 1554  
Name of Patient : Mrs. Shikha Mantei Age: 30y4 Gender: F  
Father's / Husband's Name : Mr. Siddhant Mantei Corporate / Occupation : \_\_\_\_\_  
Address : Asht Nagar Phone : 9868849019 Email : \_\_\_\_\_  
Procedure / Plan : MD/LSCS EDD/Dos: July-26  
MODE OF PAYMENT : ☒ SELF ☐ TPA : \_\_\_\_\_ ☐ GIPSA : \_\_\_\_\_ OTHER \_\_\_\_\_

## TARIFF INFORMATION :

| Particulars                                                     | Package Amounts (Rs.)                                                          |                                                                                          |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Room Category                                                   | Normal Delivery                                                                | LSCS                                                                                     |
| Multi Shared Ward                                               |                                                                                |                                                                                          |
| Shared Ward                                                     |                                                                                |                                                                                          |
| Twin Shared Ward                                                | 1.30k                                                                          | 1.410k                                                                                   |
| Private Room                                                    | 1.90k                                                                          | 1.60k                                                                                    |
| Super Deluxe Room                                               |                                                                                |                                                                                          |
| Suite Room                                                      | +myomectomy 1.1ac Enter                                                        |                                                                                          |
| Package includes<br>(Package starts from the time of admission) | Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges | Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges |
|                                                                 | Length of Stay for : <u>2 Days</u>                                             | Length of Stay for : <u>3 Days</u>                                                       |
|                                                                 | Pharmacy up to <u>9,000/-</u>                                                  | Pharmacy up to <u>12,000/-</u>                                                           |
|                                                                 | Investigations up to <u>2,500/-</u>                                            | Investigations up to <u>3,000/-</u>                                                      |
| Others                                                          | <u>Well baby care</u>                                                          | <u>251 to 351</u>                                                                        |

Neonatologist Charges : ☐ Covered ☐ Not Covered Epidural / Entonox : ☐ Covered ☐ Not Covered

Initial Minimum Deposit : 20% Advance

REMARKS : Neonatal Vaccination - SPK - B16

- Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
- Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.
- In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
- For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.
- Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
- Tariffs are subject to revision
- Kindly check your billing status on day to day basis at IP Billing Department.
- Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

## DECLARATION

I \_\_\_\_\_ have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Siddhant  
Signature of the Client

Husband  
Signatory Relationship

[Signature]  
Signature of the financial Counselor



10/2/80

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BAH-00520821 IP26-00006876  
Mrs SHIKHA MANTRI  
27-12-1995 30 Y 6 M 21 D (F)  
Dr. SWAPNA SAMUDRALA

Rainbow®  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## SURGERY DETAILS

Date: 18/7/26

Patient Name: Mrs. Shikha Mantri Date of Birth: 27/12/1995 Age: 30Yrs

Gender: Female Ward: OT UHID No: BAH-00520821

Date of Surgery: 18/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Elective LSCS with myomectomy  
↓ S.A

Time in: 10:45 am

Time Out: 12:45 pm

|                      | NAME                               | AMOUNT |
|----------------------|------------------------------------|--------|
| 1. Surgeon           | Dr. Swapna Samudrala               |        |
| 2. Anaesthetist      | Dr. Samir                          |        |
| 3. Assistant Surgeon | Dr. J.V. Reddy / Dr. Naveena       |        |
| 4. OT Technician     | Sr. Pallavi, Sr. Saravathi         |        |
| 5. Circulating Nurse | Sr. Natasha, Sr. Pooja Sr. Sushala |        |
| 6. Assistant Nurse   | Sr. Sandhya                        |        |

Mrs SHIKHA MANTRI (30 Y 6 M 21 D/ F)  
OTHERS  
HN26012033032

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator  
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa  
☐ Neuro Cusa ☐ Others

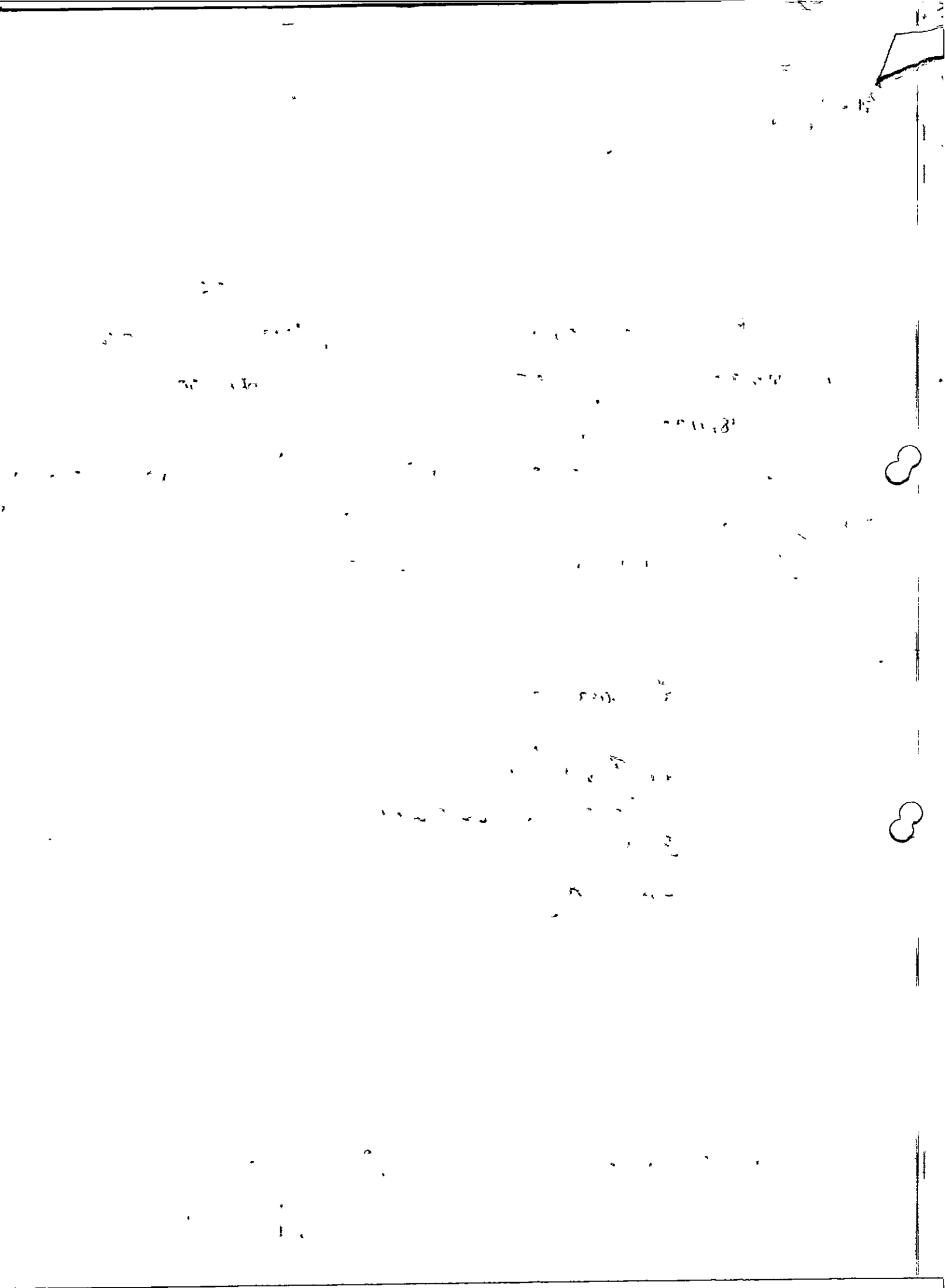
Signature of the Surgeon

Signature of Circulating Nurse

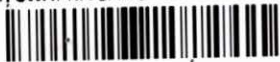
Order No: 26-00094950

Order by: Sandhya 18/7/26 @ 10:30pm

(on record card)







LSCS + Myomectomy

# CONSUMABLES OF OT

Circulating staff : Dr. Jushieela Technician : Saraswati Date : 18/7/26 Time : .....

| Anaesthesia Disposables                       | Qty    |      | Surgical Disposables                  | Qty    |      | Disposables (Baby Side)     | Qty    |      |
|-----------------------------------------------|--------|------|---------------------------------------|--------|------|-----------------------------|--------|------|
|                                               | Issued | Used |                                       | Issued | Used |                             | Issued | Used |
| ET tube                                       |        |      | Major Pack <u>LSCS pack</u>           | 01     | ✓    | Inj Vit.K                   |        | ✓    |
| LMA                                           |        |      | Sutures <u>4248 2366</u>              | 2      | ✓    | Cord Clamp                  |        | ✓    |
| ECG leads : A / P / N                         | 03     | ✓    | <del>Staple fire</del> <u>1326</u>    | 01     | ✓    | Suction Catheter            |        |      |
| HME filter : A / P / N                        |        |      | <u>4242, 5062</u>                     | 2      | ✓    | Feeding Tube                |        |      |
| Syringes : 10 cc                              | 03     | ✓    | <u>4241, 2364</u>                     | 4      | ✓    | Vacuum Suction Set          |        |      |
| 05 cc                                         | 03     | ✓    | Gloves <u>SG65</u>                    | 02     | ✓    | Surgical Gloves <u>6, 7</u> | 1      | ✓    |
| 02 cc                                         | 03     | ✓    | <u>Encore 6.5, 6</u>                  | 1      | ✓    | Gauze Pack <u>10x10</u>     | 1      | ✓    |
| 01 cc                                         | 01     | ✓    | <u>SG6.0, 5.47</u>                    | 02     | ✓    | Syringe 1ml / 2ml           | 01     | ✓    |
| Cautery plate A / P / N                       | 01     | ✓    | Surgical blade <u>22</u>              | 01     | ✓    | Surgical Blade # 20         | 01     | ✓    |
| IV set                                        | 01     | ✓    | NG tube                               |        |      | Koochies (S)                |        |      |
| RL                                            | 02     | ✓    | Cautery pencil                        | 01     | ✓    | <u>26-0000214989</u>        |        |      |
| NS : 10ml / 100ml / 500ml / 1000ml            | 02     | ✓    | Koochies <u>XXL</u>                   | 01     | ✓    |                             |        |      |
| <u>Oxytocine</u>                              | 06     | ✓    | Ointments                             |        |      | <u>Vas</u>                  |        |      |
| <u>Tranexa 1g/m</u>                           | 02     | ✓    | Suction Catheter                      |        |      | <u>Surgical 4inx8in</u>     | 02     | ✓    |
| Fentanyl                                      | 01     | ✓    | Cap, Mask                             | 10     | ✓    | <u>Misoprost</u>            | 01     | ✓    |
| Morphine                                      |        |      | Gauze Pack                            | 02     | ✓    | <u>gang</u>                 |        |      |
| Ketamine                                      |        |      | Mop Pack                              | 03     | ✓    |                             |        |      |
| Propofol <u>Midaz (5ml)</u>                   | 01     | ✓    | Steristrip                            |        |      |                             |        |      |
| <u>Recuronium Hydrocort 100mg</u>             | 01     | ✓    | Underpad                              | 02     | ✓    |                             |        |      |
| Glycopyrolate                                 |        |      | Draw sheet                            |        |      |                             |        |      |
| Myopyrolate                                   |        |      | Abgel                                 |        |      |                             |        |      |
| Ondansetron                                   |        |      | Foleys catheter                       |        |      |                             |        |      |
| <u>27g</u> <u>Pencan 25g</u> Spinal Needle 22 | 01     | ✓    | Urobag                                |        |      |                             |        |      |
| Bupivacaine 0.25%                             |        |      | Chest Drainage Catheter <u>ADK 24</u> | 01     | ✓    |                             |        |      |
| <u>Anaesthet</u> Bupivacaine 0.25% (Heavy)    | 01     | ✓    | Romodrain bag                         |        |      |                             |        |      |
| Antibiotics                                   |        |      | Bandage                               |        |      |                             |        |      |
| <u>Theracaine 2%</u>                          | 01     | ✓    | Tegaderm                              |        |      |                             |        |      |
| Suppositories                                 |        |      | Ioban                                 |        |      |                             |        |      |
| Anamol : 80mg / 250mg / 170 mg                |        |      | Double J Stent                        |        |      |                             |        |      |
| Supridol : 100mg                              | 01     | ✓    | Vacuum Suction set                    | 01     | ✓    |                             |        |      |
| Justin : 12.5 mg / 25mg / 100mg               | 01     | ✓    | Plastic Bed Sheet <u>Apron</u>        | 01     | ✓    |                             |        |      |
| Tab. Misoprost : 200mg                        | 01     | ✓    | Betadine Solution                     | 02     | ✓    |                             |        |      |
| <u>Encore glove 7.5</u>                       | 01     | ✓    | Microshield                           | 01     | ✓    |                             |        |      |
| <u>Gauze 10x10</u>                            | 01     | ✓    | Cotton Balls                          | 01     | ✓    |                             |        |      |
| <u>02 mask (A)</u>                            | 01     | ✓    | Latex Gloves                          | 20     | ✓    |                             |        |      |
| <u>3 way 10cm vein clip</u>                   | 01     | ✓    | Ramdone Scrub                         |        |      |                             |        |      |
| <u>Vasopressin</u>                            | 01     | ✓    | Saral                                 |        |      | <u>10x patch 2%</u>         | 2      | ✓    |

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. 26-0000214973/974/987

Ordered by : Sargodha

Doc. No. : RCH / FRM / GENERAL / 125

988.



## ELECTRONIC MEDICINE PRESCRIPTION

MRN : BAH-00520821 Name : Mrs SHIKHA MANTRI  
Age / Sex : 30 Y 6 M 21 D / Female Doctor : SWAPNA SAMUDRALA  
Adm/Reg Date/Time : 18/07/2026 08:30 Payor : SELFPAY  
Order Date : 18/07/2026 14:46 Ordernumber : 26-0000214973  
Visit ID : IP26-00005876 Ward/Bed No : 4F -OT / LDR-415  
Patient Address : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020

| S.No | Description                               | Generic Name                              | Dosage   | Route / Frequency      | Duration | Instruction | Qty      | Status    |
|------|-------------------------------------------|-------------------------------------------|----------|------------------------|----------|-------------|----------|-----------|
| 1    | MISOPROST TAB 200MCG 4S                   |                                           | 1 Tabs   | External / Once Daily  | 1 Days   |             | 4 Tabs   | Dispensed |
| 2    | SUPRIDOL SUPPOSITORIES 100 MG 5 S         |                                           | 1 Nos    | Injection / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 3    | BIOXAMIC 500 MG INJ                       |                                           | 1 Ampule | External / Once Daily  | 1 Days   |             | 2 Ampule | Dispensed |
| 4    | DSYRINGS 2.5ML(NIPRO)                     | SYRINGE 2ML                               | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 5    | MEZOLAM INJ 5 MG 5 ML                     |                                           | 1 Vial   | External / Once Daily  | 1 Days   |             | 1 Vial   | Dispensed |
| 6    | JUSTIN SUPPOSITORIES 100 MG 5 S           |                                           | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 7    | BCV-INTRAFIX SAFESET                      |                                           | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 8    | PREGELLED SURGICAL PLATES(ADULT)          | PREGELLED PLATED ADULT                    | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 9    | EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML         |                                           | 1 Vial   | External / Once Daily  | 1 Days   |             | 6 Vial   | Dispensed |
| 10   | DSYRINGE 5ML(NIPRO)                       | SYRINGE 5ML                               | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 11   | PENCAN 27G (B/BRAUN)                      |                                           | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 12   | DSYRINGE 10ML (NIPRO)                     | SYRINGE 10ML                              | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 13   | E.C.G ELECTRODES (ADULT)                  | ELECTRODES ADULT                          | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 14   | ANAWIN HEAVY 5 MG INJ 4 ML                |                                           | 1 Vial   | External / Once Daily  | 1 Days   |             | 1 Vial   | Dispensed |
| 15   | NS 500ML CLOSED BOTTLE                    |                                           | 1 Bottle | External / Once Daily  | 1 Days   |             | 2 Bottle | Dispensed |
| 16   | OxygenMask With Tubing - Adult ROMSONS-FC |                                           | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 17   | GAUZE PACK STERILE 10X10X12 PLY 5S        | GAUZE PACK STERILE 10X10X12 PLY 5 PACK    | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 18   | CORT-S INJ 100 MG 2 ML                    |                                           | 1 Vial   | Injection / Once Daily | 1 Days   |             | 1 Vial   | Dispensed |
| 19   | RL 500 ML CLOSED SYSTEM                   | RINGER LACTATE 500ML CLOSED               | 1 Bottle | / Once Daily           | 3 Days   |             | 3 Bottle | Dispensed |
| 20   | NS 100ML ACCULIFE - EH                    | NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO | 1 mL     | / Once Daily           | 2 Days   |             | 2 mL     | Dispensed |
| 21   | DSYRINGE 1ML (NIPRO)                      | SYRINGE 1ML                               | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 22   | THEMICAINE 2% 30ML INJ                    |                                           | 1 Nos    | Injection / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 23   | VEIN-O-LINE 10CM ROMSONS                  |                                           | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 24   | ENCORE MICROPTIC GLOVES-7.5 PF            |                                           | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |

SWAPNA SAMUDRALA

Reg No : 69924

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Note

\* This prescription is valid only for specified duration.

\* Do not refill medicines.





**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : BAH-00520821 Name : Mrs SHIKHA MANTRI  
Age / Sex : 30 Y 6 M 21 D / Female Doctor : SWAPNA SAMUDRALA  
Adm/Reg Date/Time : 18/07/2026 08:30 Payor : SELF PAY  
Order Date : 18/07/2026 14:52 Ordernumber : 26-0000214974  
Visit ID : IP26-00006876 Ward/Bed No : 4F -OT / LDR-415  
Patient Address : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020

| S.No | Description                                  | Generic Name                                     | Dosage   | Route / Frequency     | Duration | Instruction | Qty      | Status    |
|------|----------------------------------------------|--------------------------------------------------|----------|-----------------------|----------|-------------|----------|-----------|
| 1    | KIPINEX FORTE INJ 1.5 GM                     |                                                  | 1 Vial   | External / Once Daily | 1 Days   |             | 3 Vial   | Dispensed |
| 2    | ACUGYL 500MG INJ                             |                                                  | 1 Nos    | External / Once Daily | 1 Days   |             | 6 Nos    | Dispensed |
| 3    | NS 100ML ACCULIFE - EH                       | NORMALSALINE 0.9%<br>SODIUMCHLORIDE100M<br>L CLO | 1 mL     | / Once Daily          | 5 Days   |             | 5 mL     | Dispensed |
| 4    | DICLOQUICK 1ML INJ                           |                                                  | 1 Nos    | External / 10 AM      | 1 Days   |             | 3 Nos    | Dispensed |
| 5    | RELIPARA(PARACETAMOL)<br>1000MG 100ML BOTTLE |                                                  | 1 Nos    | External / Once Daily | 1 Days   |             | 4 Nos    | Dispensed |
| 6    | ADULT DIAPERS-XXL                            |                                                  | 1 Nos    | External / 10 AM      | 1 Days   |             | 3 Nos    | Dispensed |
| 7    | ESKULGUT INJ 40MG                            |                                                  | 1 Nos    | External / Once Daily | 1 Days   |             | 4 Nos    | Dispensed |
| 8    | BIOXAMIC 500 MG INJ                          |                                                  | 1 Ampule | External / Once Daily | 1 Days   |             | 6 Ampule | Dispensed |
| 9    | NITRILE EXAMINATION<br>GLOVES P F- MEDIUM    |                                                  | 1 Nos    | External / Once Daily | 1 Days   |             | 10 Nos   | Dispensed |
| 10   | RL 500 ML CLOSED SYSTEM                      | RINGER LACTATE<br>500ML CLOSED                   | 1 Bottle | / Once Daily          | 5 Days   |             | 5 Bottle | Dispensed |
| 11   | UNDERPADS 60X90<br>BUTTERFLY                 |                                                  | 1 Nos    | External / 10 AM      | 1 Days   |             | 4 Nos    | Dispensed |

**SWAPNA SAMUDRALA**

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**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : BAH-00520821 Name : Mrs SHIKHA MANTRI  
Age / Sex : 30 Y 6 M 21 D / Female Doctor : SWAPNA SAMUDRALA  
Adm/Reg Date/Time : 18/07/2026 08:30 Payor : SELF PAY  
Order Date : 18/07/2026 15:26 Ordernumber : 26-0000214987  
Visit ID : IP26-00008876 Ward/Bed No : 4F -OT / LDR-415  
Patient Address : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020

| S.No | Description                       | Generic Name                 | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status    |
|------|-----------------------------------|------------------------------|--------|-----------------------|----------|-------------|--------|-----------|
| 1    | COTTON BALLS 2 GM 5 NOS           |                              | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 2    | LSCS DRAPE PACK (PROTECTCARE)     |                              | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 3    | ROMO-ADK-24G                      | ROMOVAC SET 24               | 1 Nos  | External / 10 AM      | 1 Days   |             | 1 Nos  | Dispensed |
| 4    | SGLOVE # 6.5 (SURGICARE)          | SURGICAL GLOVES 6.5          | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Dispensed |
| 5    | SURGICEL FIBRILLAR 1INX2IN (1961) |                              | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 6    | VICRYL 1-0 NW 2364                | VICRYL 1-0 NW 2364           | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 7    | SURGICAL BLADE 20                 | SURGICAL BLADE 20            | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 8    | CATGUT 1-0 4248                   |                              | 1 Nos  | External / 10 AM      | 1 Days   |             | 2 Nos  | Dispensed |
| 9    | DISPOSABLE APRONS STERILE XL      | DISPOSABLE APRON STERILE XL  | 1 Nos  | / Once Daily          | 4 Days   |             | 4 Nos  | Dispensed |
| 10   | FACE MASK 3 LAYER - ELASTIC       | FACE MASK 3 LAYER            | 1 Nos  | External / Once Daily | 1 Days   |             | 10 Nos | Dispensed |
| 11   | LOX-LIDOCAIN-5PER PATCH 2S        |                              | 1 Nos  | External / 10 AM      | 1 Days   |             | 2 Nos  | Dispensed |
| 12   | BACTOPREP SOLUTIONS 100 ML        |                              | 1 mL   | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 13   | VACCUME SUCTION SET               |                              | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 14   | CAUTERY PENCIL(ADVANCE)           |                              | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 15   | SGLOVE # 7.0(SURGICARE)           | SURGICAL GLOVES 7.0          | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Dispensed |
| 16   | SGLOVE # 8 (SURGICARE)            | SURGICAL GLOVES 6.0          | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Dispensed |
| 17   | Encore Microptic gloves-6.5       |                              | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 18   | SURGICEL SNOW 4INX8IN (1952)      | SURGICEL SNOW 4INX8IN        | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 19   | ENCORE MICROPTIC GLOVES-6 PF      |                              | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Dispensed |
| 20   | POVINANZ SOLUTION 10% 100 ML      |                              | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Dispensed |
| 21   | TRUGUT CHROMIC CATGUT SN4242      | TRUGUT CHROMIC CATGUT SN4242 | 1 Nos  | / Once Daily          | 3 Days   |             | 3 Nos  | Dispensed |
| 22   | MERSILK 1-0 NW 5062               | MERSILK 5062                 | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 23   | MONOCRYL 3-0 NW 1326              | MONOCRYL 1326                | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 24   | VICRYL 1-0 VP 2346                | VICRYL 1-0 VP 2346           | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Dispensed |
| 25   | TRUGUT CHROMIC CATGUT SN4241      | TRUGUT CHROMIC CATGUT SN4241 | 1 Nos  | / Once Daily          | 4 Days   |             | 4 Nos  | Dispensed |
| 26   | VPRESS INJ 20 IU 1 ML             |                              | 1 Vial | External / Once Daily | 1 Days   |             | 1 Vial | Dispensed |

**SWAPNA SAMUDRALA**

**Reg No : 69924**

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## Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,  
Telangana, INDIA ,500029.  
040-48873000, info@rainbowhospitals.in



### ELECTRONIC MEDICINE PRESCRIPTION

MRN : BAH-00520821 Name : Mrs SHIKHA MANTRI  
Age / Sex : 30 Y 6 M 21 D / Female Doctor : SWAPNA SAMUDRALA  
Reg Date/Time : 18/07/2026 08:30 Payor : SELFPAY  
Order Date : 18/07/2026 15:26 Ordernumber : 26-0000214988  
Visit ID : IP26-00006876 Ward/Bed No : 4F -OT / LDR-415  
Patient Address : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020

| S.No | Description                            | Generic Name | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status    |
|------|----------------------------------------|--------------|--------|-----------------------|----------|-------------|--------|-----------|
| 1    | ADULT DIAPERS-XXL                      |              | 1 Nos  | External / 10 AM      | 1 Days   |             | 1 Nos  | Dispensed |
| 2    | UNDER PAD 60X90 10's Pack - MEDICUBE   |              | 1 Nos  | External / 10 AM      | 1 Days   |             | 2 Nos  | Dispensed |
| 3    | SURGEON CAP FEMALE SAFE SECURE         |              | 1 Nos  | External / 10 AM      | 1 Days   |             | 10 Nos | Dispensed |
| 4    | NITRILE EXAMINATION GLOVES P F- MEDIUM |              | 1 Nos  | External / Once Daily | 1 Days   |             | 20 Nos | Dispensed |

SWAPNA SAMUDRALA

Reg No : 69924

\* This document is just for reference purpose only. Not to be considered as primary report.

#### Note

\* This prescription is valid only for specified duration.

\* Do not refill medicines.

Printed Date/Time : 18/07/2026 15:47

Printed By : SUNKARI SANGEETHA

Page 1 of 1

# **Rainbow Childrens Hospital-Himayatnagar**

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,  
Telangana, INDIA ,500029.  
040-48873000, info@rainbowhospitals.in



## **ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00016662 Name : Baby Of SHIKHA MANTRI  
Age / Sex : 0 Y 0 M 0 D 4 H / Male Doctor : SPANDANA PASUPULETI  
Adm/Reg Date/Time : 18/07/2026 11:49 Payor : SELF PAY  
Order Date : 18/07/2026 15:29 Ordernumber : 26-0000214989  
Visit ID : IP26-00006877 Ward/Bed No : 4F -OT / CRDL-HNPDA-415-1  
Patient Address : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020

| S.No | Description                        | Generic Name                           | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status    |
|------|------------------------------------|----------------------------------------|--------|-----------------------|----------|-------------|--------|-----------|
| 1    | SGLOVE # 6 (SURGICARE)             | SURGICAL GLOVES 6.0                    | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 2    | CORD CLAMP-ALPHAMEDICARE           |                                        | 1 Nos  | External / 10 AM      | 1 Days   |             | 1 Nos  | Dispensed |
| 3    | INJEK INJ 1 MG 0.5 ML              |                                        | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Vial | Dispensed |
| 4    | SURGICAL BLADE 20                  | SURGICAL BLADE 20                      | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 5    | GAUZE PACK STERILE 10X10X12 PLY 5S | GAUZE PACK STERILE 10X10X12 PLY 5 PACK | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 6    | DSYRINGE 1ML (NIPRO)               | SYRINGE 1ML                            | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |
| 7    | SGLOVE # 7.0(SURGICARE)            | SURGICAL GLOVES 7.0                    | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Dispensed |

**SPANDANA PASUPULETI**

\* This document is just for reference purpose only. Not to be considered as primary report.

### **Note**

\* This prescription is valid only for specified duration.

\* Do not refill medicines.





|                        |                                                                                             |                       |                       |
|------------------------|---------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| <b>Name</b>            | Mrs SHIKHA MANTRI                                                                           | <b>UHID</b>           | BAH-00520821          |
| <b>Father/Guardian</b> | Mr SIDDHARTH MANTRI                                                                         | <b>Age/Gender</b>     | 30 Y 6 M 21 D/ Female |
| <b>Address</b>         | H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD, Ashok Nagar, Hyderabad, INDIA, 500020 |                       |                       |
| <b>IP No</b>           | IP26-00006876                                                                               | <b>Admission Date</b> | 18-07-2026            |
| <b>Ref Doctor</b>      | Self                                                                                        |                       |                       |
| <b>Discharge Date</b>  | 21.07.2026                                                                                  |                       |                       |

### DISCHARGE SUMMARY

#### **Consultant:**

Dr. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924

**Diagnosis: PRIMIGRAVIDA WITH 37<sup>+4</sup> WEEKS WITH MULTIPLE LARGE FIBROIDS COMPLICATING PREGNANCY WITH INTRAHEPATIC CHOLESTASIS OF PREGNANCY FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION + MYOMECTOMY**

**ELECTIVE LOWER SEGMENT CAESAREAN SECTION WITH MYOMECTOMY DONE ON 18.07.2026**

#### **History:**

LMP: 24.09.2025

Obstetric formula: Primi

EDD: 03.08.2026

Gestation at admission: 37<sup>+4</sup> weeks

#### **Obstetric History:**

G1 -Present Pregnancy, Spontaneous conception.

**Medical History:** Known case of multiple fibroids of uterus.

**Surgical History:** Nil.

**Allergies** : Nil.

**Family History** : Nil.

|       |                   |                |              |
|-------|-------------------|----------------|--------------|
| Name  | Mrs SHIKHA MANTRI | UHID           | BAH-00520821 |
| IP No | IP26-00006876     | Admission Date | 18-07-2026   |

### Antenatal Details:

Mrs SHIKHA MANTRI was booked to Rainbow hospital at 6 weeks of gestation. She had regular antenatal checkups and investigations as advised. Viability scan at 6 weeks showed multiple subserosal fibroids (1. posterior and right lateral pedunculated- 8.2\*5.7\*8.2 cms; 2. Fundal subserosal seedling - 4.9\*4.2\*4 cms; 3. Anterior and left lateral - 4.6\*4.4\*4.7 cms; 4. Left lateral - 2.7\*2.1\*1.8 cms; 5. left lateral - 2.4\*2.1\*2.3 cms). NT scan was normal. FTS was low risk. TIFFA was normal with Placenta - posterior low lying. At 22<sup>+6</sup> weeks patient had complaints of generalised itching and her Total bile acids were increased and LFT within normal limits, hence diagnosed with Obstetric cholestasis and was started on Tab. Udiliv 300 BD. Fetal growth monitoring was done by serial growth scan. Scan done on 15.07.2026 showed SLIUF at 37<sup>+2</sup> weeks Cephalic Presentation, EFW: 3096 gms (51%/AC: 68%) Placenta posterior -2.3cm away from OS, AFI: 19.5cms with multiple subserosal fibroids with normal doppler. She was admitted at 37<sup>+4</sup> weeks for Elective LSCS with Myomectomy.

**Investigations:** Enclosed.

Blood group: "O" Positive

### Management: Course in hospital:

At admission on clinical examination the vitals were stable, uterus was relaxed. Fetal well being was confirmed by an admission CTG which was found to be reactive. She was prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. 2 pint PRBC was reserved. Patient shifted to theatre.

### Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed

|       |                   |                |              |
|-------|-------------------|----------------|--------------|
| Name  | Mrs SHIKHA MANTRI | UHID           | BAH-00520821 |
| IP No | IP26-00006876     | Admission Date | 18-07-2026   |

in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

- \* **Loop of cord around neck.**
- \* **Posterior subserosal fibroid of 10x8cm with omental adhesions - adhesiolysis and myomectomy done .**
- \* **Fundo-anterior subserosal fibroid of 7x6cm noted and myomectomy done.**
- \* **Right lateral subserosal fibroid of 5x4cm noted and myomectomy done.**
- \* **3 small fibroids 2x3cm, 4x3cm, 4x5cm noted and myomectomy done.**
- \* **Fibroids sent for HPE**
- \* **1 Pint of PRBC transfusion started intraoperatively.**
- \* **IP drain kept in situ.**

#### Delivery Details:

Date : 18.07.2026  
Time of Delivery : 11:02am  
Type of Delivery : Elective Lower segment caesarean section with myomectomy  
Indication : Multiple large fibroids  
Anaesthesia : Spinal

#### Baby Details:

Date : 18.07.2026  
Time : 11:02am  
Sex : Male  
Weight : 2.920kg  
Apgar : 7,8  
Gestational Age: 37<sup>+</sup><sub>4</sub> weeks  
NICU Admission: No

#### Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breast feeding initiated. On POD 1 Repeat CBP and Hb was traced to be 11.5g/dl. She was shifted to room. Drain

|       |                   |                |              |
|-------|-------------------|----------------|--------------|
| Name  | Mrs SHIKHA MANTRI | UHID           | BAH-00520821 |
| IP No | IP26-00006876     | Admission Date | 18-07-2026   |

removed on POD 3. On third postoperative day dressing was changed. On inspection wound was healthy. She had complaint of generalised itching on & off, Dermatologist opinion was sought. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

#### Advice:

1. Tab. Augmentin 650mg twice daily till 24.07.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 22.07.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 22.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 24.07.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Nebasulf Powder for local application.
8. Continue Tab Udiliv 300 mg (Ursodeoxycholic acid) twice daily (10 am-10pm) till further order.
9. Repeat LFT and TBA after 2 weeks.
10. Collect HPE report.
11. USG pelvis after 6 weeks.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

\* Suggest **PAP smear** and **HPV Vaccine** after 6weeks; Please discuss with your treating doctor regarding **HPV vaccination**.

Review with **Dr. SWAPNA SAMUDRALA** after **2 weeks** on **04.08.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

**For Women Who Have Had a Caesarean Section**



|              |                   |                       |              |
|--------------|-------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs SHIKHA MANTRI | <b>UHID</b>           | BAH-00520821 |
| <b>IP No</b> | IP26-00006876     | <b>Admission Date</b> | 18-07-2026   |

### Care of the wound:

1. You can bath and shower.
2. The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3. This gauze piece needs to be discarded after one use.
4. Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
5. Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6. Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**

**Registrar/Resident/C.M.O**

### Consultant:

Dr. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924



## ADMISSION SHEET

### Registration Details :



**Admission No** : IP26-00006876      **Admit Date** : 18-Jul-2026      **Admit Time** : 08:30 AM      **UHID** : BAH-00520821

### Patient Details :

|                                                                                                              |                                           |
|--------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| <b>Patient Name</b> : Mrs SHIKHA MANTRI                                                                      | <b>Age</b> : 30 Y 6 M 21 D                |
| <b>Guardian</b> : Mr SIDDHARTH MANTRI                                                                        | <b>DOB</b> : 27-12-1995                   |
| <b>Gender</b> : Female                                                                                       | <b>Religion</b> :                         |
| <b>Occupation</b> :                                                                                          | <b>Martial Status</b> : Married           |
| <b>Address (H)</b> : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD Ashok Nagar Hyderabad INDIA 500020 | <b>Phone No</b> : 9848849919/ 9394594084  |
|                                                                                                              | <b>E-mail</b> : MANTRISIDDHARTH@GMAIL.COM |

### Admission Details :

**Bed Type** : TWIN SHARING      **Bed No** : LDR-415      **Ward Name** : 4F -OT  
**Room No** : LDR-415      **Admission Type** : First Visit

### Contact Details :

**Name** : Mr SIDDHARTH MANTRI      **Relationship** : W/O  
**Contact Address** : H.NO: 1-10-175, STREET NO:08, ASHOK NAGAR, HYDERABAD Ashok Nagar Hyderabad INDIA 500020      **Phone No** : 9848849919

  
Signature

### Doctor Details :

**Doctor Name** : Dr. SWAPNA SAMUDRALA      **Specialisation** : OBSTETRICS AND GYNECOLOGY  
**Referral Doctor** : Self      **Phone No** :  
**Co-Consultant** :

### Payment Details :

**Deposit Amount** : 120000.00  
**Payment Mode** : DC/CC Card      **Payor Name** : SELFPAY





## DEFICIENCY CHECK LIST OF CASE SHEET

| Sl.No. | List of Records                            | No. of Pages | Legibility | Completeness | Remarks |
|--------|--------------------------------------------|--------------|------------|--------------|---------|
| 1      | Admission sheet                            | 1            |            |              |         |
| 2      | Discharge Summary                          | 1            |            |              |         |
| 3      | Nursing Initial assessment                 | 1            |            |              |         |
| 4      | Patient Transfer form                      | 1            |            |              |         |
| 5      | In-patient Medical record                  | 1            |            |              |         |
| 6      | Doctors progress sheets                    | 5            |            |              |         |
| 7      | Nursing plan of care and handover sheets   | 3            |            |              |         |
| 8      | Consultation sheet                         |              |            |              |         |
| 9      | General consent for treatment              | 1            |            |              |         |
| 10     | Consent for Surgery                        | 1            |            |              |         |
| 11     | Consent for blood transfusion              |              |            |              |         |
| 12     | Consent for chemotherapy                   |              |            |              |         |
| 13     | Consent for high risk                      |              |            |              |         |
| 14     | Consent for Restraint                      |              |            |              |         |
| 15     | LAMA consent                               |              |            |              |         |
| 16     | Consent for special procedure / Sedation   |              |            |              |         |
| 17     | Consent for Formula feed                   |              |            |              |         |
| 18     | Consent for MTP                            |              |            |              |         |
| 19     | Consent for Radiological Investigations    |              |            |              |         |
| 20     | Consent for HIV test                       |              |            |              |         |
| 21     | Anaesthesia notes (Pre Anaesthesia & post) | 1            |            |              |         |
| 22     | Neonatal Admission/Delivery/Physical Exam  | 1            |            |              |         |
| 23     | Medication Reconciliation                  | 1            |            |              |         |
| 24     | Emergency Triage record                    |              |            |              |         |
| 25     | Pre operative check list                   | 1            |            |              |         |
| 26     | Surgical safety checklist                  | 1            |            |              |         |
| 27     | Operation Theatre notes                    | 1            |            |              |         |
| 28     | Nurses clinical Presentation               |              |            |              |         |
| 29     | TPR & BP chart                             | 3            |            |              |         |
| 30     | Intake and Out take chart (fluid chart)    | 2            |            |              |         |
| 31     | Drug chart (Regular Prescription)          | 1            |            |              |         |
| 32     | Investigation Values (result sheet)        | 1            |            |              |         |
| 33     | Nebulization chart                         |              |            |              |         |
| 34     | Nutritional review chart                   | 1            |            |              |         |
| 35     | Intensive care unit (ICU Charts)           |              |            |              |         |
| 36     | Consent for Admission in PICU / NICU       |              |            |              |         |
| 37     | The Humpty dumpty scale                    |              |            |              |         |
| 38     | Braden Q Scale                             | 2            |            |              |         |
| 39     | Bed side check list                        |              |            |              |         |
| 40     | PICU bed formula Dilution feeds            |              |            |              |         |
| 41     | Gastro monitoring chart                    |              |            |              |         |
| 42     | Rch ED doctors note                        |              |            |              |         |
| 43     | BP Monitoring chart                        |              |            |              |         |
| 44     | RBS monitoring chart                       |              |            |              |         |
|        | Billing                                    | 1            |            |              |         |
|        | Others                                     | 5            |            |              |         |
|        | <b>Total No. of Pages</b>                  | <b>37</b>    |            |              |         |

## ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /  
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



AGI monitoring 8<sup>th</sup> hourly

11:30pm 106cm

1:30am :- 96cm

10:30AM :- 102cm.

3:30pm - 109cm

10pm - 103 cm

~~21/2~~  
8am - 100 cm

12 3 4 5 6 7 8 9 10 11 12

13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500

501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                         |                                   |                                                                                                                                                                 |                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Patient Name & UHID No.<br>BAH-00520821 IP26-00006876<br>Mrs SHIKHA MANTRI<br>27-12-1995 30 Y 6 M 22 D (F)<br>Dr. SWAPNA SAMUDRALA<br> |                                   | Date & Time of Admission<br>18/7/26 @                                                                                                                           | Date & Time of Transfer Order<br>18/7/26 @ 2pm |
|                                                                                                                                                                                                                         |                                   | Transfer Ordered by<br>Dr. neweend.                                                                                                                             | Reason for Transfer<br>obs                     |
| From Unit<br>pre-post                                                                                                                                                                                                   | To Unit<br>305                    | Information to Attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                            |                                                |
| Number of Sheets in Clinical File                                                                                                                                                                                       | Number of Imaging Films           | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                       |                                   |                                                                                                                                                                 |                                                |
| Sl.No.                                                                                                                                                                                                                  | Item Name                         | Quantity                                                                                                                                                        |                                                |
| 1.                                                                                                                                                                                                                      | Rh                                | 3                                                                                                                                                               |                                                |
| 2.                                                                                                                                                                                                                      | Ins. metformin                    | 3                                                                                                                                                               |                                                |
| 3.                                                                                                                                                                                                                      | Insulin + Tab. Calpal 500mg       | 1 + 15                                                                                                                                                          |                                                |
| 4.                                                                                                                                                                                                                      | Insulin ES-Kalyan + Kipinor Forte | 2 + 1                                                                                                                                                           |                                                |
| 5.                                                                                                                                                                                                                      | Insulin Dillorfenol               | 1                                                                                                                                                               |                                                |
| Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                   |                                   |                                                                                                                                                                 |                                                |
| Name & Signature of Person who is Transferring<br>Chandra Kulkarni                                                                                                                                                      |                                   | Name of Person Ordered Transfer<br>Dr. neweend.                                                                                                                 |                                                |
| Patient & Clinical Records Received by :<br>Moutushi                                                                                                                                                                    |                                   |                                                                                                                                                                 |                                                |
| Date & Time of Patient Received : @ 2:10pm 19/7/26                                                                                                                                                                      |                                   |                                                                                                                                                                 |                                                |

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready







## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

## WARD TRANSFERS

| Date    | Time     | From     | To       | Signature of Nurse |
|---------|----------|----------|----------|--------------------|
| 17/7/26 | 10:30 AM | Pre-post | OT       | chandrabala/Karung |
| 18/7/26 | 12:50 PM | OT       | Pre-Post | Karung/CD          |
| 19/7/26 | 2 PM     | Pre-Post | Floor    | CD                 |
|         |          |          |          |                    |
|         |          |          |          |                    |

## Cross Consultation Visit

|    | Doctors Name              | Date    | Order No. | Signature |
|----|---------------------------|---------|-----------|-----------|
| 1  | Dr. S. TEJASWI (Sathurka) | 20/7/26 | 5411      | Srinu     |
| 2  |                           |         |           |           |
| 3  | Dr. Sneha Reddy           | 21/7/26 | 15682     | Srinu     |
| 4  |                           |         |           |           |
| 5  |                           |         |           |           |
| 6  |                           |         |           |           |
| 7  |                           |         |           |           |
| 8  |                           |         |           |           |
| 9  |                           |         |           |           |
| 10 |                           |         |           |           |

## INVESTIGATIONS

[illegible]

## MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



# PROCEDURE

| Date    | Procedure         | Quantity | Order No. | Signature |
|---------|-------------------|----------|-----------|-----------|
| 18/7/26 | IV placement      | ①        | 214891    | Cindy     |
| 18/7/26 | Catheterization   | ①        | 225237    | Am        |
|         | PAC               | ①        | 14975     | Ana       |
| 18/7/26 | Blood Transfusion | 1        |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
| 18      |                   |          |           |           |
| 20/7/26 | NHA               | ①        | 5395      |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |

press check done

## ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

|             |              |                   |                    |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|             |              |                   |                    |





## IP ADMISSION SHEET FOR OBSTETRICS

### Presenting Complaints

Gone for ELUS  
 PFM

Obstetric Formula: PFM

### Obstetric History:

G. - PP, Spont Conception

Present Pregnancy Record: Book @ GWS

NT - (1) FIS

T11FA - (1)

Uterus size - @ GWS (multiple fibroids)

**RISK FACTORS:** 82 X 57 X 82 (Posterior (2nd & 3rd are))  
 49 X 42 X 40 (Fundal Subserosal)  
 40 X 44 X 42 (Anterior (1st & 2nd are))

Ascd obst cholestasis @ 23 Weeks - Uterus 30cm BD

Utero multiple fibroids (subserosal)

LMP: 24/9/2015

EDD: 1/7/26

Corrected EDD: 3/8/26

GA: 37 weeks 5 days

Menstrual History: Regular : ☐ Yes ☐ No

### Obstetric Examination

Fundal Height: ~36wk

Ut. Activity: ☒ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others \_\_\_\_\_

Head Fifts Palpable: \_\_\_\_\_

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

### Per Speculum Examination not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

### Vaginal Examination not done

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed \_\_\_\_\_ Dilated \_\_\_\_\_

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 1.58..... cm

Weight: 74.50..... kg

Allergies: ..... not

Breast: ☒ Normal ☐ Abnormal

General Examination: PFM

Consciousness: (1)

Pallor: (1)

Icterus: (1)

Edema: (1)

Temp: 98.6

PR: (1)

BP: (1)

DTR: (1)

CVS: (1) MHO

RS: (1) BMT

Liver/Spleen: (1)

Urine Output: Adeq

### DIAGNOSIS

PM / 37wks 5days fibroid complicating Pregnancy / obst cholestasis

for ELUS + Myomectomy

Family History:

nil

Surgical History:

nil

Medical History:

nil

Medication History:

Tob Iron / Calciu  
Tob Vit D 3000 80

Plan of Care:

- Admission NST
- Days to check
- Wt vitals & SRV
- Inform Axen / Pedcare
- Pains prepare
- Inform Informant
- check / Reserve 20 PRBC
- Foley's catheterization
- Shift to OT on call
- NBM
- pre op medication.

Investigations:

BQT 0 @ Bme

TBA - 3.80 / LFT WNC

15/7

CBL (15/7/16)

-AB - 11.7 g/dl

-Hb - 8.46 g/dl

Plat count - 3.26 lakh

PCV - 33.5%

HIV - NR

HbA1c - NR

VDRL - NR

BCV - Neg

29/6

Total Bilocalid - 3.80 mmol/l

T-Bil - 0.4 mg/dl

SGOT - 17 U/L

SGPT - 16 U/L

USG (16/6/2016)

SUP 33+ wk / oblique lie

EFW - 2206 gm (52% / Ae 49%)

PL - Post-Row - 2cm away from OS

AP2 - 15.3 cm

UAD @

Multiple fibroids

Doppler - normal

Multiple subserosal fibroids

15/7

SUP 37+2 day

plac - post - 2.3 cm away from OS.

AFI - 19.5 cm

EFW - 3096 g (51<sup>st</sup> centile)

Doctor Name: Dr. Manish

Signature: [Signature]

Date & Time: 18/7/2016

Dr. Swapna Samudrala  
Consultant Obstetrics and Gynecology  
Reg. No. 69924

Consultant Name: Dr. Swapna S.

Signature: [Signature]

Date & Time: 18/7/2016





| Date & Time                                                                  | Progress Notes                                                                                                                          | Doctor's Order                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 18/12/26                                                                     | POD - 0                                                                                                                                 | (P.L. / El. here - Myomectomy)                                                                                                                                                                                                        |
| 1:15 pm                                                                      | NO comp<br>O/E - G.C. Jani<br>w/abundant<br>O. Lat - 992 RA<br>PR - 72 bh<br>B.P - 96 / 70 mmHg<br>P/A - ut well retracted<br>K/E - MAT | ① PRBC on flow<br>Adv<br>NBM till further orders<br>IV / analgesic<br>Thrombocytopenia - now<br>- Drugs as checked<br>- mobilize vitals 1/2 hourly<br>w/ excessive AB<br>bleeding<br>- 2/2, Drain Output<br>charting<br>- Sigan free. |
| Saline well<br>O.O - 1000<br>Clean<br>Drain - mi<br>Serve<br>CPR on 18/12/26 |                                                                                                                                         |                                                                                                                                                                                                                                       |
|                                                                              |                                                                                                                                         | Dr. Swapna Samudrala<br>Consultant Obstetrics and Gynecology<br>Reg. No: 69924                                                                                                                                                        |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                                                   | Doctor's Order                                                                                                                                                                     |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 18/7/26<br>8:40 PM | C/S/B Dr. Dha<br>No complaints<br>B/L Breast soft - AC fair<br>Baby & Mother<br>Afebrile<br>BP: 100/80 mmHg<br>PR: 66/min<br>D/O - 100ml<br>U/O - 400ml<br>Clear | Adv.<br>- NBM till further order.<br>- IV fluids<br>- Drugs as charted<br>- W/F bleeding PV.<br>- Drain care<br>- I/O checking<br>- Monitor vitals<br>- Infom 808<br>- CBC +fm 6AM |
| 19/7/26<br>8:15 PM | C/S/B Dr. Dha<br>No complaints<br>AC fair<br>Afebrile<br>BP: 108/69 mmHg<br>PR: 77/min<br>H/CNAB<br>P/A Uterus Retracted well<br>BS(P)<br>U/E NAB                | Adv.<br>- Oral sips.<br>- IV fluids<br>- Drugs as charted<br>- W/F bleedng PV<br>- Drain care.<br>- I/O checking<br>- Monitor vitals<br>- Infom 808                                |





| Date & Time          | Progress Notes                                                                                                                                                                                                                                                                                                                                                                                           | Doctor's Order                                                                                                                                                                                                                                                                                       |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 19/7/2026<br>10:00am | <p>obs by Dr Naveena</p> <p>OLC GC-Fair</p> <p>CBP (19th) Alebrile. <math>\text{SpO}_2</math> 99%<br/>Hb - 11.5gms PR: on RA<br/>BP:<br/>TLC - 14,000<br/>P/H - 2.6/1.4<br/>C/S / RS: NAD.<br/>PA: ut. retracted well.<br/>S/LT, NT.<br/>Dressing: dry &amp; clean<br/>Bowel sounds: present<br/>UE: PV bleeding. WNL<br/>ULO: 80-90ml/hr.<br/>clear.<br/>d/o: 190ml. Serious.<br/>Baby: Motherside.</p> | <p>Adv</p> <ul style="list-style-type: none"> <li>- Sips of water.</li> <li>- Adequate hydration</li> <li>- drugs as charted</li> <li>- Urine I/O charting</li> <li>- Drain OLP charting.</li> <li>- w/F PV bleeding.</li> <li>- Monitor Vitals</li> <li>- Inform SCS.</li> </ul> <p>Dr. Naveena</p> |



# PROGRESS NOTES AND DOCTOR'S ORDER

Date  
& Time

Progress Notes

Doctor's Order

19/2/26

POB - 2

(P.L. / hrs) myomectomy  
 1 D PRBC ↓

11:00 PM

No Comp  
 Pt comfortable / analgesia

Baby well

O/E - Gc Jan  
 up to date

Vital signs

O<sub>2</sub> Sat - 99% on Rn

Uterus

Vitals - @

P/A - ut well retracted

Uterus, Bx -

Prain - 190 ml  
 Serum

A/E - MVB

- Sigh Det
- Oral Hydration
- Analgesia
- Foley removed
- Drugs as charted
- monitor vitals
- Sugar 800

Shift to Room

Dr. [Signature]

noted by [Signature]

Dr. Swapna Samudrala  
 Consultant Obstetrics and Gynecology  
 Reg. No: 69924





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time          | Progress Notes         | Doctor's Order             |
|----------------------|------------------------|----------------------------|
| 19/7/2026<br>3:10 pm | cls by Dr. Naveena     |                            |
| ✓                    | ole GC-fair            | Ado                        |
| ✓                    | Afebrile               | - Soft diet                |
| U-✓                  | Vitals - stable        | - Adequate hydration       |
| F-✓                  | PA: ut. retracted well | - drugs as charted         |
| S-✓                  | Soft, NT               | - Ambulation               |
|                      | Dressing: dry & clean  | - Drain OP                 |
|                      | lfe: PV bleeding WNL   | charted                    |
|                      | blo: some              | - Monitor Vitals           |
|                      | Baby: Motherside       | - Inform SOS               |
|                      |                        | Dr. Naveena                |
| 19/7/2026<br>7:30 pm | cls by Dr. Naveena     |                            |
| ✓                    | ole GC-fair            | Ado                        |
| ✓                    | Afebrile               | ✓ Soft diet                |
| U-✓                  | Vitals - stable        | ✓ Adequate hydration       |
| F-✓                  | PA: ut. retracted well | ✓ drugs as charted         |
| S-✓                  | Soft, NT               | ✓ Ambulation               |
|                      | Dressing: dry & clean  | ✓ Drain OP charted         |
|                      | Distension - present   | ✓ Ty: Perineum long intact |
|                      | BS - present           | ✓ Monitor Vitals           |
|                      | lfe: PV bleeding WNL   | ✓ Inform SOS               |
|                      | blo: some 2pm          | Dr. Naveena                |

BAH-00520821

IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995

30 Y 6 M 22 D

(F)

Dr. SWAPNA SAMUDRALA



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                       | Doctor's Order                    |
|---------------------|--------------------------------------|-----------------------------------|
| 19/7/2026<br>9:45pm | cls by. Dr. Naveena<br>cls giddyness |                                   |
|                     | ole GC-fair                          | Ado                               |
|                     | Alebrile SpO <sub>2</sub> -99% on RA | - clear                           |
|                     | PR: 82bpm                            |                                   |
|                     | BP: 112/78mmHg                       |                                   |
| do- 6am             | CosRS: NAD                           |                                   |
| 2pm                 | PA: ut. retracted well               |                                   |
| 105cm               | Soft distension ++                   |                                   |
| AG -                | Bowel sounds: present                |                                   |
| F-X                 | Dressing: dry & clean                |                                   |
| U-✓                 | UE: AV, bleeding WNL                 |                                   |
| S-X                 | Baby: Mother's side.                 |                                   |
|                     | cls by Dr. Swapna                    |                                   |
|                     |                                      | Ado                               |
|                     |                                      | clear liquids only.               |
|                     |                                      | AG charting: 8 <sup>th</sup> hrly |
|                     |                                      | iv fluids - 30                    |
|                     |                                      | drugs as charted                  |
|                     |                                      | Dulcolax suppositories            |
|                     |                                      | & PR stat                         |
|                     |                                      | Monitor Vitality                  |
|                     |                                      | Inform SOS                        |
|                     | Dr. Naveena                          | Noted by Divya                    |
|                     |                                      | 19/7/26                           |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                                              | Doctor's Order                                                                                                                                                                                                                      |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20/7/2026<br>7:00am | cls by Dr Naveena                                                                                                                                                                                           |                                                                                                                                                                                                                                     |
|                     | <p>OLG GC-Fair</p> <p>Alebrile</p> <p>PR: 76bpm</p> <p>BP: 117/74 mm Hg</p> <p>CUS RS: NAD</p> <p>PA: soft NT</p> <p>Dressing dry &amp; clean</p> <p>mini. distension</p> <p>UE: PV bleeding WNL</p>        | <p>Adv</p> <p>clear liquids</p> <p>Adequate hydration</p> <p>drugs as charted</p> <p>Drain OLP charting</p> <p>w/lf PV bleeding</p> <p>AG charting 8th hrly.</p> <p>Monitor Vitals</p> <p>Inform SOS</p> <p>STERIZONE DRESSING.</p> |
|                     | Baby: Mother's side.                                                                                                                                                                                        | <p>Noted by Divya</p> <p>20/7/26</p> <p>Dr. Naveena</p> <p>TODAY</p>                                                                                                                                                                |
| 20/7/26<br>3pm      | <p>Chlo Dr Naveena</p> <p>POD-2</p> <p>OLG GC-Fair</p> <p>PR: 76bpm</p> <p>BP: 104/67 mm Hg</p> <p>PA: uterus antedated well</p> <p>plw bleeding bleeding</p> <p>Baby - mother's side.</p> <p>DO - 25ml</p> | <p>Adv</p> <p>1. Soft diet</p> <p>2. Adequate hydration</p> <p>3. Drugs as charted</p> <p>4. AG charting 8th hrly.</p> <p>5. Sterizone Dressing</p> <p>6. Monitor Vitals</p> <p>7. Supp. med.</p>                                   |
|                     |                                                                                                                                                                                                             | <p>Shubh</p>                                                                                                                                                                                                                        |



# PROGRESS NOTES AND DOCTOR'S ORDER

Date  
& Time

Progress Notes

Doctor's Order

20/1/20  
5:30 PM

POD-1

No comp  
O/E - G.c. per  
PR - sub

BP - 117/86 mmHg

PLA - uterus anteflexed well

Mild abdominal distention (+)  
BS - present well heard

Baby well

Uterus  
Shrink ✓  
Faint

Drain 25 ml  
Serum

Dr. Swapna Samudrala  
Consultant Obstetric and Gynecology  
Reg. No. 10000000000000000000

- Adv
1. Soft diet
  2. Adequate Hydration
  3. Drugs as charted
  4. AC monitoring
  5. D/o monitoring
  6. Dressing and Drain removal tomorrow.
  7. Monitor Vital Signs

(Signature)

20/1/20  
5:30 PM

CLINICAL Dr. Samudrala  
POD-2

Clot itching of both lower limbs and back  
off + chills

apex 4

PR - 79 bpm

BP - 109/69 mmHg

PLA - uterus anteflexed well

Uterus - no hardening  
Both lower limbs - multiple  
petechial lesions (+)

U ✓

F ✓

S ✓

Baby mother

Olo - 25 ml  
Faint

- Adv
1. Soft diet
  2. Adequate Hydration
  3. Drugs as charted
  4. AC monitoring
  5. D/o monitoring
  6. Dressing and Drain removal tomorrow.
  7. Monitor Vital Signs

(Signature)

Dr. S. Samudrala

N.B. M. Rupprecht  
20/1/20





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                                                                                         | Doctor's Order                                                                                                                       |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 20/1/26<br>8pm     | CL/B Dr. Mundula<br>Rt clo Itching of Lower limbs<br>Gc-jain<br>Vitals - Stable<br>P/A - uterus retracted well<br>O/E - Both limbs - multiple pustular lesions                                         | Adv<br>1. Drugs as charted<br>2. Derma Dew calce Lotion for Local application<br>3. Dermatologist opinion<br>4. Tab. UDILV 300mg BD  |
|                    | Dr. Mundula. NB Sunanda                                                                                                                                                                                |                                                                                                                                      |
| 21/1/26<br>8:30 AM | CL/B Dr. Durg<br>POD-3<br>No complaints<br>Baby & Mother.<br>Gc fair<br>Afebrile<br>Vitals - stable<br>P/A Uterus retracted well.<br>U ✓<br>CV ✓<br>S ✓<br>Ct PV bleed wml.<br>D/O - Minimal<br>← 15ml | Adv<br>- Regular diet<br>- Drugs as charted<br>- Adequate hydration<br>- Dermatologist opinion<br>- Monitor vitals<br>- Infant's sox |
|                    |                                                                                                                                                                                                        | Ap                                                                                                                                   |

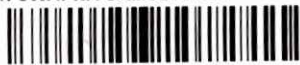




## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                 | Doctor's Order                                                                                                                 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| 21/9/26<br>11:30 AM | POD - III<br>No Comp<br>OIE - G. Organ<br>Edema<br>Vital - 99 2 RA<br>Vital - @<br>P/A - ut well retracted<br>Wound - (H) / Drain removed<br>ASD None<br>Wound Care<br>S/E S ✓ | Adv<br>Regular Diet<br>Oral Hydration<br>Drugs as charted<br>Monitor vitals<br>Ambulation<br>Supp Sec.<br>NB Mouthwash @ 12 PM |
|                     | Can be dis charged                                                                                                                                                             | Ch. (Signature)                                                                                                                |
|                     | Dr. Swapna Samudrala<br>Consultant Obstetrics and Gynecology<br>Reg. No. 69924                                                                                                 |                                                                                                                                |

BAH-00520821 IP26-00006876  
Mrs SHIKHA MANTRI  
27-12-1995 30 Y 6 M 22 D (F)  
Dr. SWAPNA SAMUDRALA



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## NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 20/07/26 Time: 8:30 am

Origin: Indian Height: 158 cm Weight: 74.50 kg BMI:  $\sim 26 \text{ kg/m}^2$   
 $\sim 28 \text{ kg/m}^2$   
 $\sim 30 \text{ kg/m}^2$   
Food Allergies: No 29 kg/m<sup>2</sup>

Diagnosis: LSCS

Type of Diet: ☐ Liquid ☐ Soft ☐ Normal ☐ Diabetic ☒ Clear Liquid  
☒ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's

Signature: Siddhant

Name: Shikha

Date & Time: 20/7/26;

Doc. No. : RCH / FRM / CLINICAL / 195

Dietician's

Signature: Sobiya

Name: Syeda Syeda Zaher

Date & Time: 20/7/26;

(P. T. O)

### DIETARY NOTES

[illegible]





## MEDICATION RECONCILIATION FORM

Drug Allergies: .....

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

 Shifting From: ..... NA .....

 Shifted to: ..... NA .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|-------------------------------------------------------------------|
| 1    | <u>Tab Iron</u>                                   | <u>1 tab</u>      | <u>PO</u>                 | <u>OD</u> | <u>17/7</u>              | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 2    | <u>Tab Calcein</u>                                | <u>1 tab</u>      | <u>PO</u>                 | <u>OD</u> | <u>17/7</u>              | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 3    | <u>Tab VDILV</u>                                  | <u>300mg</u>      | <u>PO</u>                 | <u>BD</u> | <u>17/7</u>              | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 4    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 5    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 6    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 7    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 8    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 9    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 10   |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

 Doctor Name & Signature: ..... D. Mantri .....

 Date & Time: ..... 18/7/2016 C 9AM .....

 Nurse Name & Signature: ..... Chambakale .....

 Date & Time: ..... 18/7/2016 @ 9AM .....

Docu. No. : RCH / FRM / GENERAL / 090





305

## RESULT SHEET

|                     |         |         |  |  |  |  |
|---------------------|---------|---------|--|--|--|--|
| Date                | 15/8/26 | 19/8/26 |  |  |  |  |
| Time                |         | 6AM     |  |  |  |  |
| Hb                  | 11.7    | 11.5    |  |  |  |  |
| PCV                 |         | 32.9    |  |  |  |  |
| RBC                 |         | 3.88    |  |  |  |  |
| WBC                 |         | 14.13   |  |  |  |  |
| N/L                 |         |         |  |  |  |  |
| Platelets           |         | 276     |  |  |  |  |
| CRP                 |         |         |  |  |  |  |
| ESR                 |         |         |  |  |  |  |
| PCT                 |         |         |  |  |  |  |
| RBS                 |         |         |  |  |  |  |
| Na                  |         |         |  |  |  |  |
| K                   |         |         |  |  |  |  |
| Cl                  |         |         |  |  |  |  |
| Ca/Mg               |         |         |  |  |  |  |
| Phosphate           |         |         |  |  |  |  |
| Urea                |         |         |  |  |  |  |
| Creatinine          |         |         |  |  |  |  |
| ALP                 |         |         |  |  |  |  |
| SGPT                |         |         |  |  |  |  |
| SGOT                |         |         |  |  |  |  |
| T.Bill/Conj         |         |         |  |  |  |  |
| T.Protein           |         |         |  |  |  |  |
| S.Albumin           |         |         |  |  |  |  |
| S.Globulin          |         |         |  |  |  |  |
| A/G Ratio           |         |         |  |  |  |  |
| Uric Acid           |         |         |  |  |  |  |
| S.Amylase           |         |         |  |  |  |  |
| Sr.Lipase           |         |         |  |  |  |  |
| Blood Lactate       |         |         |  |  |  |  |
| S.Cholesterol       |         |         |  |  |  |  |
| PT/INR              |         |         |  |  |  |  |
| APTT                |         |         |  |  |  |  |
| CSF Protein / Sugar |         |         |  |  |  |  |
| Cells               |         |         |  |  |  |  |
| N/L                 |         |         |  |  |  |  |



|                 |             |  |  |                          |  |  |
|-----------------|-------------|--|--|--------------------------|--|--|
| Date            |             |  |  |                          |  |  |
| Time            |             |  |  |                          |  |  |
| CUE - Alb       |             |  |  |                          |  |  |
| CUE - Sugar     |             |  |  |                          |  |  |
| CUE - Ketones   |             |  |  |                          |  |  |
| CUE - PUS Cells |             |  |  |                          |  |  |
| CUE - RBC Cells |             |  |  |                          |  |  |
| CUE             |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |
| Stool Pus Cell  |             |  |  |                          |  |  |
| OVA / Cyst      |             |  |  |                          |  |  |
| Occult Blood    |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |
| Blood grouping  | Dispositive |  |  | 20 pRBC Resave           |  |  |
|                 |             |  |  | Sonyal Blood bank.       |  |  |
| HIV             | } N.A.      |  |  |                          |  |  |
| HbsAg           |             |  |  | 10 pRBC transfusion done |  |  |
| HCV             |             |  |  | Today 18/1/26            |  |  |
|                 |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |
|                 |             |  |  |                          |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

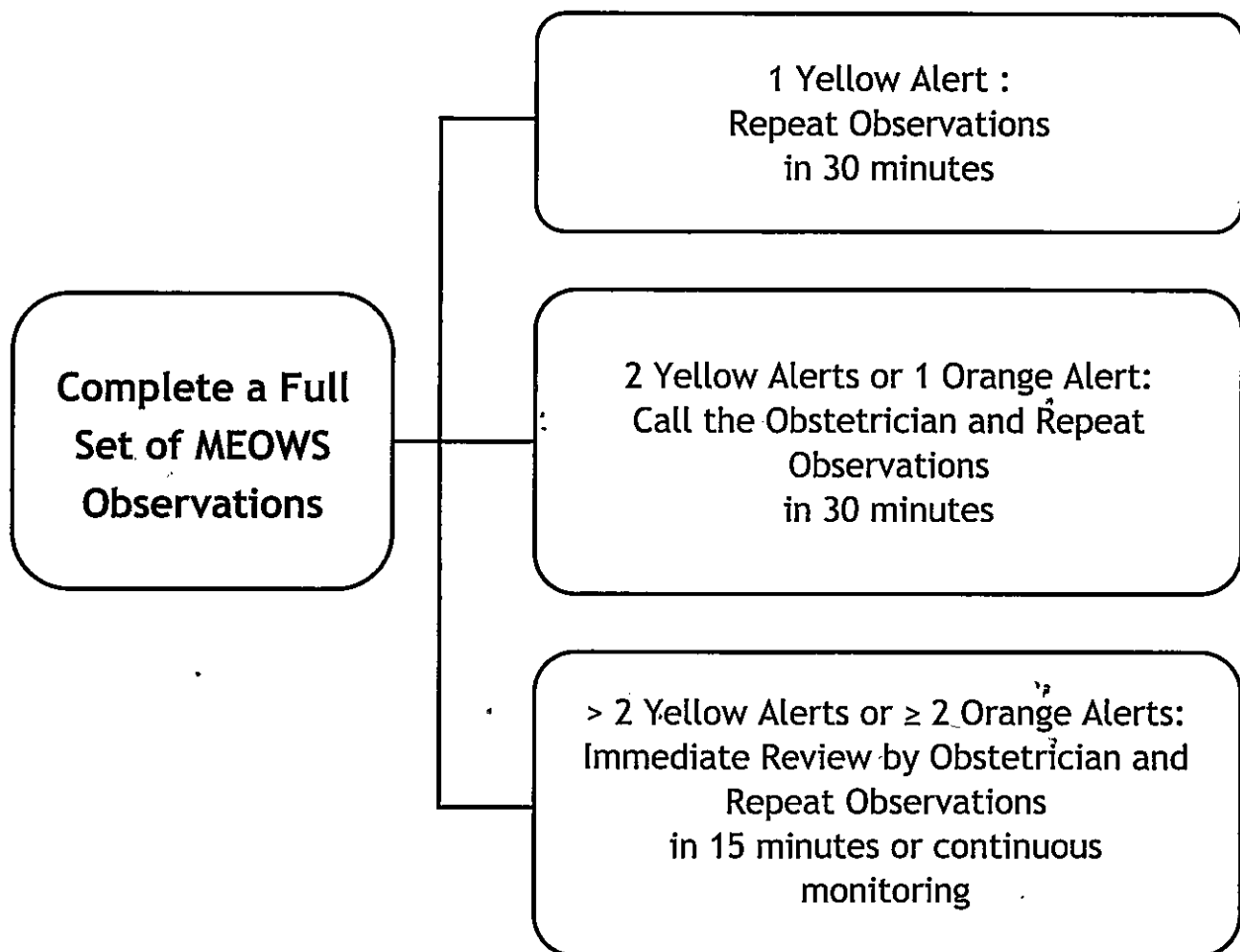
Others (ECG, Contrast Studies etc.,) : .....



Dr. SWAPNA SAMUDRALA

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



(F)

IP26-00006876

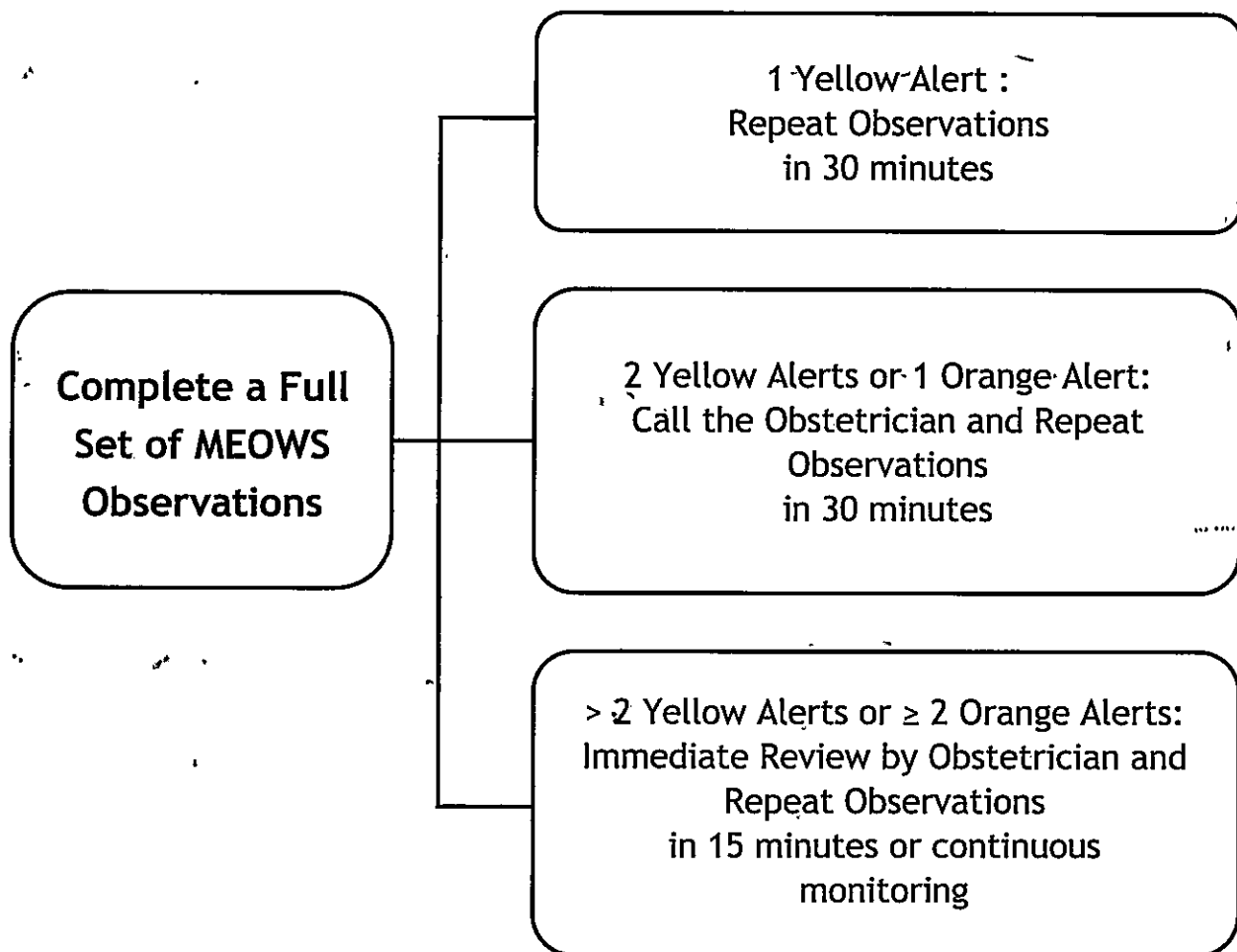


## Early Warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

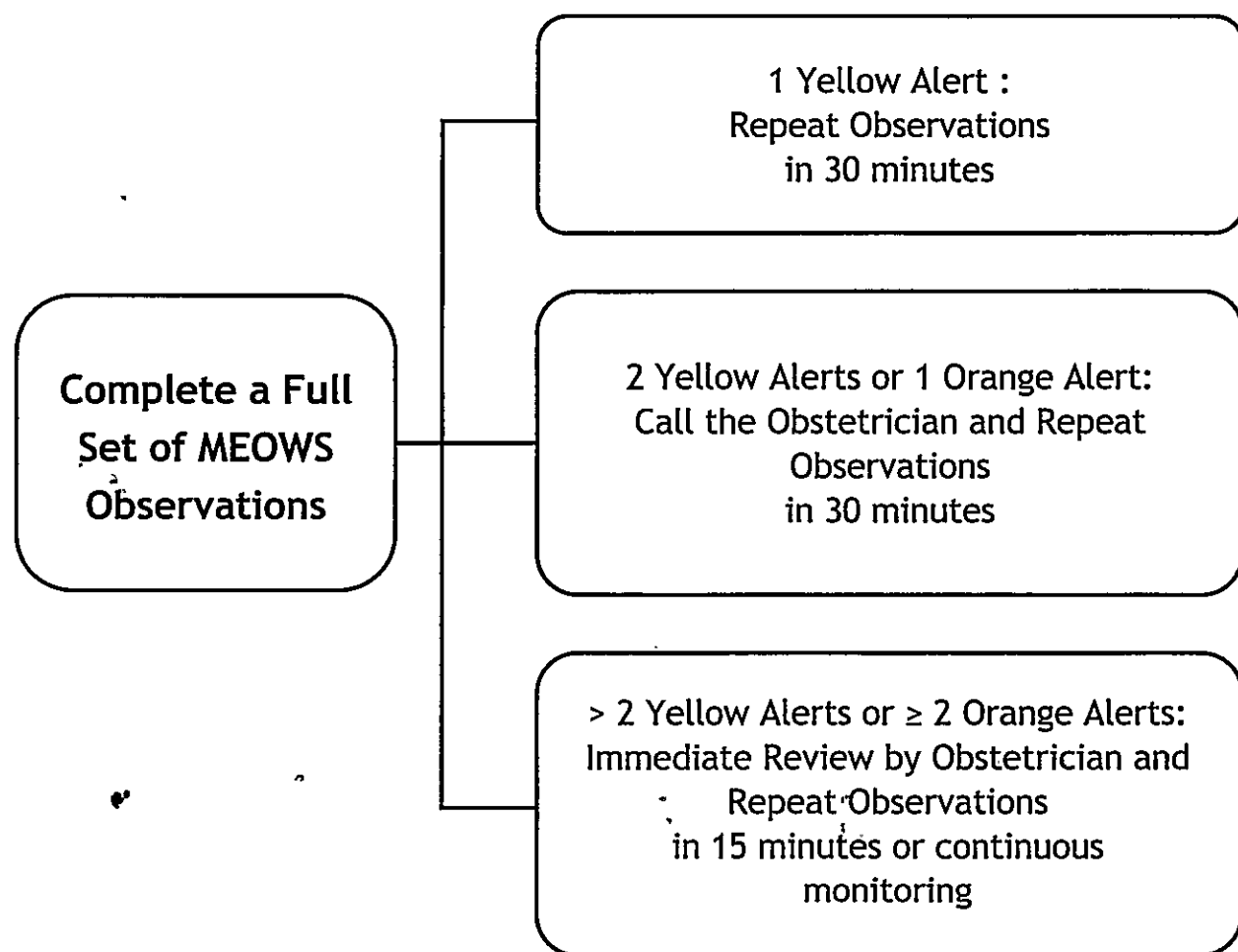




| Date                                    |                          | Time  |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|-----------------------------------------|--------------------------|-------|---|----|----|----|---|---|---|---|---|---|---|---|---|----|----|----|---|---|---|---|---|---|---|--|
|                                         |                          | 8     | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |  |
| RESP<br>(write rate in<br>corresp. box) | > 30                     |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 21 - 30                  |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 11 - 20                  |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 0 - 10                   |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Saturations                             | 94 - 100 %               |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | < 94 %                   |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Administered O <sub>2</sub> (L/min.)    |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Temp °C                                 | 40                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 39                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 38                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 37                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 36                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 35                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | < 35                     |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Heart Rate                              | 170                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 160                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 150                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 140                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 130                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 120                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 110                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 100                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 90                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 80                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 70                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 60                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 50                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| 40                                      |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Systolic Blood Pressure<br>↑            | 190                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 180                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 170                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 160                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 150                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 140                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 130                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 120                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 110                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 100                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 90                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 80                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 70                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| 60                                      |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| 50                                      |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Diastolic Blood Pressure<br>↓           | 130                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 120                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 110                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 100                      |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 90                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 80                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 70                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 60                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 50                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | 40                       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | NEURO<br>RESPONSE<br>[✓] | Alert |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         |                          | Voice |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         |                          | Pain  |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Unresponsive                            |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| URINE<br>mls / hour                     | > 30                     |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | < 30                     |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Proteinuria                             | Protein ++               |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | Protein > ++             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Lochia                                  | Normal                   |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | Heavy / Foul             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Liquor                                  | Clear / Pink             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
|                                         | Green                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| TOTAL YELLOW SCORES                     |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| TOTAL ORANGE SCORES                     |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |
| Nurse Initial                           |                          |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

## FLUID CHART

Sheet No. : 1

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

| Date                 | Time     | Nature of Fluid | Intake |     |     | Output               |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |
|----------------------|----------|-----------------|--------|-----|-----|----------------------|-----------|-------|----------|-------|--------------------------------|-------------|
|                      |          |                 | Mouth  | I.V | N.G | NG                   | Diarrhoea | Vomit | Drainage | Urine |                                |             |
| 18/12/26             | 08:00 am | RL              | 100ml  |     |     |                      |           |       |          | ✓     |                                |             |
|                      | 09:00 am | RL              | 100ml  |     |     |                      | ✓         |       |          |       |                                |             |
|                      | 10:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 11:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 12:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 01:00 pm | RL + PRBE       | 100ml  |     |     |                      |           |       |          |       | 150ml                          |             |
| Total Intake :       |          |                 | 600ml  |     |     | Total Output :       |           |       |          |       | 150ml                          |             |
| 18/12/26             | 02:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 03:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 04:00 pm | RL              | 100ml  |     |     |                      | NA        |       |          |       |                                |             |
|                      | 05:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 06:00 pm | RL              | 100ml  |     |     |                      |           |       |          | 600ml |                                |             |
|                      | 07:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
| Total Intake :       |          |                 | 600ml  |     |     | Total Output :       |           |       |          |       | 600ml                          |             |
| 18/12/26             | 08:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 09:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 10:00 pm | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 11:00 pm | RL              | 100ml  |     |     |                      | NA        |       |          | 400ml |                                |             |
|                      | 12:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 01:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
| Total Intake :       |          |                 | 600ml  |     |     | Total Output :       |           |       |          |       | 400ml                          |             |
| 18/12/26             | 02:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 03:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 04:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
|                      | 05:00 am | RL              | 100ml  |     |     |                      | NA        |       |          |       |                                |             |
|                      | 06:00 am | RL              | 100ml  |     |     |                      |           |       |          | 500ml |                                |             |
|                      | 07:00 am | RL              | 100ml  |     |     |                      |           |       |          |       |                                |             |
| Total Intake :       |          |                 | 600ml  |     |     | Total Output :       |           |       |          |       | 500ml                          |             |
| Total 24 hrs. Intake |          |                 | 2400ml |     |     | Total 24 hrs. Output |           |       | 2150ml   |       |                                |             |





## FLUID CHART

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

| Date           | Time     | Nature of Fluid       | Intake           |       |     | NG             | Output    |       |          |       |  | IV Site Thrombophlebitis Score | Sign. Nurse |
|----------------|----------|-----------------------|------------------|-------|-----|----------------|-----------|-------|----------|-------|--|--------------------------------|-------------|
|                |          |                       | Mouth            | I.V   | N.G |                | Diarrhoea | Vomit | Drainage | Urine |  |                                |             |
| 18/12/26       | 08:00 am | RL + H <sub>2</sub> O | 100ml            |       |     |                |           |       |          |       |  |                                |             |
|                | 09:00 am | RL                    | 100ml            |       |     |                |           |       |          |       |  |                                |             |
|                | 10:00 am | RL                    | 100ml            |       |     |                |           |       |          |       |  |                                |             |
|                | 11:00 am | RL + H <sub>2</sub> O | 100ml            |       |     |                |           |       | 300ml    |       |  |                                |             |
|                | 12:00 pm | RL                    | 100ml            |       |     |                |           |       |          |       |  |                                |             |
|                | 01:00 pm | RL                    | 100ml            |       |     |                |           |       |          |       |  |                                |             |
| Total Intake : |          |                       | 600ml            |       |     | Total Output : |           |       | 300ml    |       |  |                                |             |
| 19/12/26       | 02:00 pm |                       |                  |       |     |                |           |       | 200ml    |       |  |                                |             |
|                | 03:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
|                | 04:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
|                | 05:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
|                | 06:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
|                | 07:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
| Total Intake : |          |                       | Taken            |       |     | Total Output : |           |       | U I M-O  |       |  |                                |             |
| 19/12/26       | 08:00 pm |                       |                  |       |     |                |           |       |          |       |  |                                |             |
|                | 09:00 pm | PL                    | 200ml            | 100ml |     |                |           |       |          |       |  |                                |             |
|                | 10:00 pm | PL                    | H <sub>2</sub> O | 100ml |     |                |           |       |          |       |  |                                |             |
|                | 11:00 pm | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 12:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 01:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
| Total Intake : |          |                       | Taken            |       |     | Total Output : |           |       | U - M -  |       |  |                                |             |
| 20/12/26       | 02:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 03:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 04:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 05:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 06:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
|                | 07:00 am | PL                    |                  | 75ml  |     |                |           |       |          |       |  |                                |             |
| Total Intake : |          |                       | Taken            |       |     | Total Output : |           |       | U - M -  |       |  |                                |             |

Total 24 hrs. Intake

Total 24 hrs. Output



## FLUID CHART

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

| Date                 | Time     | Nature of Fluid | Intake          |      |     | Output                 |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse  |
|----------------------|----------|-----------------|-----------------|------|-----|------------------------|-----------|-------|----------|-------|--------------------------------|--------------|
|                      |          |                 | Mouth           | I.V  | N.G | NG                     | Diarrhoea | Vomit | Drainage | Urine |                                |              |
| 20/7/26              | 08:00 am | RL              | Soup            | 25ml |     |                        |           |       | 100ml    |       |                                | empty 8:40am |
|                      | 09:00 am | RL              | <del>Soup</del> | 25ml |     |                        |           |       |          | ✓     |                                |              |
|                      | 10:00 am | RL              |                 | 25ml |     |                        |           |       |          |       |                                |              |
|                      | 11:00 am |                 |                 |      | NA  |                        |           |       | ✓        |       |                                |              |
|                      | 12:00 pm |                 |                 |      |     |                        |           |       | ✓        |       |                                |              |
|                      | 01:00 pm |                 |                 |      |     |                        |           |       |          |       |                                |              |
| Total Intake : Taken |          |                 |                 |      |     | Total Output : U-3 M-1 |           |       |          |       |                                |              |
| 20/7/26              | 02:00 pm |                 |                 |      |     |                        |           |       |          |       | 0                              | 0            |
|                      | 03:00 pm |                 | Jelly           |      |     |                        |           |       |          | ✓     | 0                              |              |
|                      | 04:00 pm |                 | H2O             |      |     |                        |           |       |          |       | 0                              |              |
|                      | 05:00 pm |                 |                 |      | NA  |                        |           |       |          |       | 0                              |              |
|                      | 06:00 pm |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
|                      | 07:00 pm |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
| Total Intake :       |          |                 |                 |      |     | Total Output :         |           |       |          |       |                                |              |
| 20/7/26              | 08:00 pm |                 |                 |      |     |                        |           |       |          |       | 0                              | 0            |
|                      | 09:00 pm |                 | Jelly           |      |     |                        |           |       |          | ✓     | 0                              |              |
|                      | 10:00 pm |                 | Whiche          |      |     |                        |           |       |          |       | 0                              |              |
|                      | 11:00 pm |                 |                 |      | NA  |                        |           |       |          |       | 0                              |              |
|                      | 12:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
|                      | 01:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
| Total Intake :       |          |                 |                 |      |     | Total Output : U- M-   |           |       |          |       |                                |              |
| 21/7/26              | 02:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              | 0            |
|                      | 03:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
|                      | 04:00 am |                 | H2O             |      |     |                        |           |       |          | ✓     | 0                              |              |
|                      | 05:00 am |                 |                 |      | NA  |                        |           |       |          |       | 0                              |              |
|                      | 06:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
|                      | 07:00 am |                 |                 |      |     |                        |           |       |          |       | 0                              |              |
| Total Intake :       |          |                 |                 |      |     | Total Output : U- M-   |           |       |          |       |                                |              |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

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 Mrs SHIKHA MANTRI  
 27-12-1995 30 Y 6 M 23 D (F)  
 Dr. SWAPNA SAMUDRALA



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## FLUID CHART

Sheet No. : .....

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

| Date                  | Time     | Nature of Fluid | Intake |     |     | Output                |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|
|                       |          |                 | Mouth  | I.V | N.G | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                |             |
| 21/7/20               | 08:00 am | 1               |        |     |     |                       |           |       | 80ml     |       |                                |             |
|                       | 09:00 am | 0               |        |     |     |                       |           |       |          |       |                                |             |
|                       | 10:00 am | 0               |        |     |     |                       |           |       |          |       |                                |             |
|                       | 11:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 12:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 01:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |
|                       | 02:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 04:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 05:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 06:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |
|                       | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |
|                       | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |

Total 24 hrs. Intake

Total 24 hrs. Output



BAH-00520821

IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995 30 Y 6 M 21 D (F)

Dr. SWAPNA SAMUDRALA



# NURSING CARE RECORD

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Date: 15/12/20

## Goals

- |                                                           |                                                               |                                                 |                                                                |                                                           |                                                     |
|-----------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Maintain Airway and Oxygenation  | <input checked="" type="checkbox"/> Relieve Pain & Discomfort | <input type="checkbox"/> Maintain Fluid Balance | <input checked="" type="checkbox"/> Improve Activity Tolerance | <input type="checkbox"/> Maintain Good Nutritional Status | <input type="checkbox"/> Maintain Skin Integrity    |
| <input type="checkbox"/> Maintain Personal Hygiene        | <input type="checkbox"/> Prevent Infection                    | <input type="checkbox"/> Meet Elimination Needs | <input type="checkbox"/> Ensure Safety                         | <input type="checkbox"/> Early Ambulation Reduce Anxiety  | <input type="checkbox"/> Patient & Family Education |
| <input type="checkbox"/> Identify Potential Complications |                                                               |                                                 |                                                                |                                                           |                                                     |
| <input type="checkbox"/> Any Others. Specify.....         |                                                               |                                                 |                                                                |                                                           |                                                     |

|           | Time             | Plan of Care                                                                                                            | Time             | Implementation                                                                                                                      | Evaluation       | Re-Assessment               | Nurse Name & Signature |
|-----------|------------------|-------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------|------------------------|
| Morning   | 8AM<br>to<br>2pm | → Assess the pt condition<br>→ Monitor vitals<br>→ maintain I/O chart                                                   | 8AM<br>to<br>2pm | → Assessed the pt condition<br>→ monitored vitals<br>→ maintain I/O chart                                                           | now pt is stable | Re-check vitals             | manu                   |
| Afternoon |                  |                                                                                                                         |                  | day's duty                                                                                                                          |                  |                             | Cand CP                |
| Night     | 8PM<br>to<br>8AM | → Assess the pt condition<br>→ monitor vitals & record<br>→ administered of medication<br>→ maintain I/O chart & record | 8PM<br>to<br>8AM | → Assessed the pt condition<br>→ monitored the vitals & record<br>→ Administration of medication<br>→ maintained I/O chart & record | pt is stable     | Monitor the vitals & record | Akele                  |



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 Mrs SHIKHA MANTRI  
 27-12-1995 30 Y 6 M 22 D (F)  
 Dr. SWAPNA SAMUDRALA



## NURSING CARE RECORD

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Date: 19/2/20

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

|           | Time | Plan of Care                                                                                                     | Time | Implementation                                                                                                       | Evaluation            | Re-Assessment                        | Nurse Name & Signature |
|-----------|------|------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|------------------------|
| Morning   | 8am  | plan for vitals                                                                                                  | 8am  | vitals Normal                                                                                                        | Normal                | stable                               | Aulher                 |
|           | 1pm  | plan for medi-<br>cation<br>- cat<br>- plan for I/O chart                                                        | 1pm  | medication<br>as per chart<br>- I/O chart<br>maintained                                                              |                       |                                      |                        |
| Afternoon | 2pm  | plan for Ambulation                                                                                              | 2pm  |                                                                                                                      | Pt is<br>stable       | Rechecked<br>vitals                  | manisha                |
|           | 2pm  | - Assess the Pt Condition<br>- monitor vitals<br>- maintain I/O chart<br>- medication given as<br>per drug chart | 2pm  | - Assessed the Pt Condition<br>- monitored vitals<br>- maintain I/O chart<br>- medication given as<br>per drug chart |                       |                                      |                        |
| Night     | 8pm  | - Assess the patient<br>condition<br>- monitor the v/s<br>- maintain the I/O<br>- Drug as per<br>chart           | 8pm  | - Assess the patient<br>condition<br>- monitor the v/s<br>- maintain the I/O<br>- Drug as per<br>chart               | - Now pt is<br>stable | - Rechecked<br>the v/s &<br>Recorded | Ry                     |
|           | 10pm |                                                                                                                  | 10pm |                                                                                                                      |                       |                                      |                        |
| Night     | 8am  |                                                                                                                  | 8am  |                                                                                                                      |                       |                                      |                        |
|           |      |                                                                                                                  |      |                                                                                                                      |                       |                                      |                        |

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IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995

30 Y 6 M 22 D

(F)

Dr. SWAPNA SAMUDRALA



## NURSING CARE RECORD

**Rainbow Children's Hospital**  
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Date: 20/7/20

## Goals

- ☒ Maintain Airway and Oxygenation  
☒ Maintain Personal Hygiene  
☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort  
☒ Prevent Infection  
☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance  
☐ Meet Elimination Needs

- ☒ Improve Activity Tolerance  
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status  
☐ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity  
☒ Patient & Family Education

|           | Time | Plan of Care                                                                   | Time | Implementation                                                                 | Evaluation                                                                                  | Re-Assessment                                          | Nurse Name & Signature |
|-----------|------|--------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------|
| Morning   | 8am  | Assess general condition                                                       | 8pm  | Assessed general condition                                                     | pt st.<br>Stable                                                                            | rechecked<br>vital                                     | Manohar                |
|           | 1    | Checked vitals & recorded<br>Administered medications<br>as per doctor advised | 1    | checked vitals & recorded<br>Administered medications<br>as per doctor advised |                                                                                             |                                                        |                        |
|           | 2pm  | Ob chart maintain                                                              | 2pm  | Ob Chart maintained                                                            |                                                                                             |                                                        |                        |
| Afternoon | 2pm  | → To assess the pt. condition<br>→ To check the vitals &<br>record             | 2pm  | → To assessed the pt. condition<br>→ To checked the vitals &<br>recorded       | → Patient is stable<br>→ Drain catheter is<br>present<br>→ Sterizone dressing<br>to be done | → Re-checked the<br>vitals<br>→ I/O<br>→ AG 8th hourly | Supriya                |
|           | to   | → To adm. the medication<br>as per drug chart                                  | to   | → To adm. the medication<br>as per drug chart                                  |                                                                                             |                                                        |                        |
|           | 8pm  | → I/O chart maintain                                                           | 8pm  | → I/O chart maintained                                                         |                                                                                             |                                                        |                        |
| Night     | 8pm  | Assess the pt<br>condition                                                     | 8pm  | Assess the pt<br>condition                                                     | Now pt is<br>stable<br>Drain catheter<br>is present                                         | Rechecked<br>the v/s                                   | SL                     |
|           | to   | Monitor the v/s<br>maintain the I/O                                            | to   | Monitor the v/s<br>maintain the I/O                                            |                                                                                             |                                                        |                        |
|           | 8am  | Drug as per<br>chart                                                           | 8am  | Drug as per<br>chart                                                           |                                                                                             |                                                        |                        |



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 Dr. SWAPNA SAMUDRALA



Patient Sticker

# NURSING CARE RECORD

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Date: 21/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

|           | Time            | Plan of Care                                                                                                    | Time            | Implementation                                                                                                  | Evaluation    | Re-Assessment     | Nurse Name & Signature         |
|-----------|-----------------|-----------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------|---------------|-------------------|--------------------------------|
| Morning   | 8AM<br>/<br>2PM | → Assess the general condition of Pt.<br>→ Monitor vitals.<br>→ Maintain I/O chart.<br>→ Administer medication. | 8AM<br>/<br>2PM | → Assess the general condition of Pt.<br>→ Monitor vitals.<br>→ Maintain I/O chart.<br>→ Administer medication. | Pt is stable. | Re-assess vitals. | <i>[Signature]</i><br>Moulishi |
| Afternoon |                 |                                                                                                                 |                 |                                                                                                                 |               |                   |                                |
| Night     |                 |                                                                                                                 |                 |                                                                                                                 |               |                   |                                |





## PAIN ASSESSMENT FORM

| Date    | Time  | Pain Score (0/10) | Location | Duration                                                                                | Acuity                                                                        | Character                                                                                                                                   | Modifying Factors                                                                     | Patient / Family Educated                                              | Intervention | Sign |
|---------|-------|-------------------|----------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------|------|
| 18/7    | 6 AM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 18/7/26 | 11 AM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 18/7    | 3 PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 18/7    | 11 PM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 19/7    | 5 AM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 19/7    | 10 AM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 19/7    | 2 PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 19/7/20 | 8 PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 20/7/26 | 12 AM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |
| 20/7/26 | 6 AM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | NA   |

**Re-assessment Frequency:**

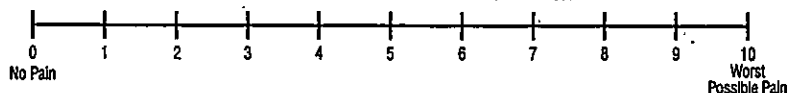
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams or sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

| Assessment Criteria                  | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|--------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                      | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| Crying Irritability                  | No Cry with painful stimuli                             | Moans or cries minimally with painful stimuli               | Appropriate crying Not Irritable              | Irritable or crying at intervals consolable                                                | High-pitched or silent-continuous cry Inconsolable                                                                                                      |
| Behavior State                       | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| Facial Expression                    | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| Extremities Tone                     | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| Vital Signs RR, BP, SaO <sub>2</sub> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

Wong - Baker (Pediatrics) Above 7 Years





## PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|---------|------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 20/7/21 | 10pm | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 20/7/26 | 3pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 20/7/26 | 10pm | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 21/7/26 | 2am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 21/7/26 | 6am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
| 21/7/26 | 10pm | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | NA   |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |

**Re-assessment Frequency:**

- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

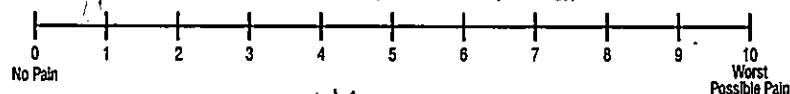


# PAIN ASSESSMENT TOOLS

**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

**Numerical Pain Scale (Obstetric and Gynecology)**



**Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)**

| Assessment Criteria                            | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| <b>Crying Irritability</b>                     | No Cry with painful stimuli                             | Moans or cries minimally with painful stimuli               | Appropriate crying Not Irritable              | Irritable or crying at intervals consolable                                                | High-pitched or silent-continuous cry Inconsolable                                                                                                      |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

**Wong - Baker (Pediatrics) Above 7 Years**



BAH-00520821

IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995

30 Y 6 M 21 D

(F)

Dr. SWAPNA SAMUDRALA



## BRADEN 'Q' SCALE

Rainbow  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 18/7  | 18/12/26 | 19/3/19 | 19/3 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------|----------|---------|------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 11:30 | 11       | 11      | 11   |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          |        | 4     | 4        | 4       | 4    |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    |        | 4     | 4        | 4       | 4    |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.                                                                                                                  | <b>2. Very limited:</b><br>responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.                                                                                                                               | <b>3. Slightly limited:</b><br>Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    |        | 4     | 4        | 4       | 4    |
| Moisture Degree to which skin is exposed to moisture                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   |        | 4     | 4        | 4       | 4    |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.                                                                                                                    | <b>3. Potential problem:</b><br>Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         |        | 4     | 4        | 4       | 4    |
| Nutritional Usual food intake pattern                                                                                                                                        | <b>1. Very Poor:</b><br>NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | <b>2. Inadequate:</b><br>Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | <b>3. Adequate:</b><br>Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. |        | 4     | 4        | 4       | 4    |
| Tissue Perfusion & Oxygenation                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               |        | 4     | 4        | 4       | 4    |
| <b>TOTAL SCORE</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |        | 28    | 28       | 28      | 28   |
| <b>Evaluator's Name</b>                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |        | 100   | 100      | 100     | 100  |

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH / FRM / CLINICAL / 119

| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice) |
|-------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15-18       | At Risk       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                               | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                                    | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                            | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



BAH-00520821

IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995

30 Y 6 M 22 D

(F)

Dr. SWAPNA SAMUDRALA



## BRADEN 'Q' SCALE

Rainbow  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 19/7 | 20/7 | 20/7 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------|------|------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 10PM | E2   | N1   |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4      | 4    | 4    | 4    |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4      | 4    | 4    | 4    |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.                                                                                                                  | <b>2. Very limited:</b><br>responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.                                                                                                                               | <b>3. Slightly limited:</b><br>Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4      | 4    | 4    | 4    |
| Moisture Degree to which skin is exposed to moisture                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4      | 4    | 4    | 4    |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.                                                                                                                    | <b>3. Potential problem:</b><br>Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4      | 4    | 4    | 4    |
| Nutritional Usual food intake pattern                                                                                                                                        | <b>1. Very Poor:</b><br>NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | <b>2. Inadequate:</b><br>Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | <b>3. Adequate:</b><br>Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4      | 4    | 4    | 4    |
| Tissue Perfusion & Oxygenation                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4      | 4    | 4    | 4    |
| <b>TOTAL SCORE</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 28     | 28   | 28   | 28   |
| <b>Evaluator's Name</b>                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | CS     | CS   | CS   | CS   |

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH / FRM / CLINICAL / 119

| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice) |
|-------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15-18       | At Risk       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |





## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 18/12 | 18/12/26 | 19/12/26 | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|-------|----------|----------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | M6    | N2       | M        | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |       |          |          |                   |                        |                                                  |
|                                                      | No                            | 0           |       |          |          |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |       |          |          |                   |                        |                                                  |
|                                                      | No                            | 0           | 0     | 0        | 0        |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |       |          |          | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | Crutches, Cane(S), Walker     | 15          |       |          |          |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0     |          |          |                   |                        |                                                  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20    | 20       | 20       | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |       |          |          |                   |                        |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          |       |          |          |                   |                        |                                                  |
|                                                      | Weak (uses touch for balance) | 10          |       |          |          |                   |                        |                                                  |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0     | 0        | 0        |                   |                        |                                                  |
| Mental Status                                        | Forgets limitations           | 15          |       |          |          | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Oriented to own ability       | 0           |       |          |          |                   |                        |                                                  |
| Total Morse Fall Scale Score:                        |                               |             | 20    | 20       | 20       |                   |                        |                                                  |
| Signature                                            |                               |             | Ch    | Q        | AW       |                   |                        |                                                  |

Tick (✓) whichever precaution taken.

### Risk Level and Interventions

#### Low Risk (0 - 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

#### Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

#### High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs



BAH-00520821

IP26-00006876

Mrs SHIKHA MANTRI

27-12-1995

30 Y 6 M 22 D

(F)

Dr. SWAPNA SAMUDRALA



**Rainbow  
Children's  
Hospital**  
It takes a lot to treat the little.

**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 19/7/20            | 20/7/20            | 20/7/20            | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|--------------------|--------------------|--------------------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | N <sub>1</sub>     | M <sub>6</sub>     | E <sub>2</sub>     | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |                    |                    |                    |                   |                        |                                                  |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |                    |                    |                    |                   |                        |                                                  |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |                    |                    |                    | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | Crutches, Cane(S), Walker     | 15          |                    |                    |                    |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0                  | 0                  | 0                  |                   |                        |                                                  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20                 | 20                 | 20                 | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          |                    |                    |                    |                   |                        |                                                  |
|                                                      | Weak (uses touch for balance) | 10          |                    |                    |                    |                   |                        |                                                  |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0                  | 0                  | 0                  |                   |                        |                                                  |
| Mental Status                                        | Forgets limitations           | 15          |                    |                    |                    | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Oriented to own ability       | 0           |                    |                    |                    |                   |                        |                                                  |
| Total Morse Fall Scale Score:                        |                               |             | 20                 | 20                 | 20                 |                   |                        |                                                  |
|                                                      |                               | Signature   | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> |                   |                        |                                                  |

Tick (✓) whichever precaution taken.

### Risk Level and Interventions

#### Low Risk (0 – 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

#### Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

#### High Risk ( ≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs





## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 18/7/26

Date of Removal: 19/7/26

| Parameters                                       | Date                                                                | Shift Time | M5                                                                  | VAR6                                                                | N1                                                                  | 19/7                                                                | M                                                                   | 19/7/26                                                             | E2                                                                  |                                                          |                                                          |                                                          |
|--------------------------------------------------|---------------------------------------------------------------------|------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Need for the Catheter                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hand Hygiene                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Usage of Sterile Equipment                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the Collection bag below the level of bladder | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Check the Tube for Obstruction (Free of Kinking) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Catheter dated as policy                      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Collecting bag is been emptied regularly?        | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Maintenance of closed system for the catheter    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dressing clean and dry?                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the line removed as Policy?                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Performance of Perineal Care                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Onset of New Fever                               | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asses for the leakage at the site of insertion   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of the Nurse                                | Madhvi                                                              |            | Madhvi                                                              | Madhvi                                                              | Madhvi                                                              | Madhvi                                                              | Madhvi                                                              | Madhvi                                                              | Madhvi                                                              |                                                          |                                                          |                                                          |
| Signature of the Nurse                           |                                                                     |            |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: LDR Date of Admission: .....

|                                          |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| SITUATION                                | Diagnosis:                                                                                                                                     | <u>EL-1818 + myomectomy</u>                                         |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|                                          | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
| BACKGROUND                               | Area                                                                                                                                           | <u>18/12</u>                                                        | <u>18/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>20/12</u>                                                        |
|                                          | Shift Time                                                                                                                                     | <u>M6</u>                                                           | <u>01</u>                                                           | <u>M</u>                                                            | <u>E2</u>                                                           | <u>N1</u>                                                           | <u>M6</u>                                                           |
| ASSESSMENT                               | Medical Condition<br>(Any special condition to be noted):                                                                                      |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|                                          | Allergy:                                                                                                                                       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| ASSESSMENT                               | Tubes/Drains/Catheter:                                                                                                                         | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Vital Signs:                                                                                                                                   | Temp: <u>98.1</u>                                                   | Temp: <u>98.1</u>                                                   | Temp: <u>98.1</u>                                                   | Temp: <u>98.6</u>                                                   | Temp: <u>98.6</u>                                                   | Temp: <u>98.5</u>                                                   |
|                                          | Res:                                                                                                                                           | <u>21</u>                                                           | <u>20bmt</u>                                                        | <u>20</u>                                                           | <u>20bmt</u>                                                        | <u>22b/m</u>                                                        | <u>20bmt</u>                                                        |
|                                          | SpO <sub>2</sub> :                                                                                                                             | <u>99</u>                                                           | <u>98.1</u>                                                         | <u>99.1</u>                                                         | <u>99.1</u>                                                         | <u>99.1</u>                                                         | <u>100</u>                                                          |
|                                          | Pulse:                                                                                                                                         | <u>82</u>                                                           | <u>87bmt</u>                                                        | <u>90</u>                                                           | <u>83</u>                                                           | <u>92bmt</u>                                                        | <u>90bmt</u>                                                        |
|                                          | BP:                                                                                                                                            | <u>110/60</u>                                                       | <u>110/62</u>                                                       | <u>122/62</u>                                                       | <u>120/80</u>                                                       | <u>122/88</u>                                                       | <u>125/60</u>                                                       |
|                                          | Fall Risk Score:                                                                                                                               | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            |
|                                          | Pain Score:                                                                                                                                    | <u>-</u>                                                            | <u>0/10</u>                                                         | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            |
| Recommendations                          | Safety Needs:                                                                                                                                  | <u>-</u>                                                            | <u>yes</u>                                                          | <u>yes</u>                                                          | <u>yes</u>                                                          | <u>yes</u>                                                          | <u>yes</u>                                                          |
|                                          | Physiotherapy                                                                                                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Others Specify:                                                                                                                                | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            |
|                                          | Special Diet:                                                                                                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Other Special Orders / Medications:                                                                                                            | <u>OR</u>                                                           | <u>NA</u>                                                           | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            | <u>-</u>                                                            |
| Post Operative Procedure Special Orders: |                                                                                                                                                | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>-</u>                                                            | <u>-</u>                                                            |
| Handed Over By Name :                    |                                                                                                                                                | <u>Nouvi</u>                                                        | <u>AKWIS</u>                                                        | <u>Arul</u>                                                         | <u>Arul</u>                                                         | <u>Suranda</u>                                                      | <u>Arul</u>                                                         |
| Signature :                              |                                                                                                                                                | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  |
| Date:                                    |                                                                                                                                                | <u>18/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>20/12</u>                                                        | <u>20/12</u>                                                        |
| Time:                                    |                                                                                                                                                | <u>2pm</u>                                                          | <u>8am</u>                                                          | <u>2pm</u>                                                          | <u>8pm</u>                                                          | <u>8am</u>                                                          | <u>9am</u>                                                          |
| Taken Over By Name :                     |                                                                                                                                                | <u>Arul</u>                                                         | <u>Arul</u>                                                         | <u>Arul</u>                                                         | <u>Suranda</u>                                                      | <u>Arul</u>                                                         | <u>Supriya</u>                                                      |
| Signature :                              |                                                                                                                                                | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  | <u>(Signature)</u>                                                  |
| Date:                                    |                                                                                                                                                | <u>18/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>19/12</u>                                                        | <u>20/12</u>                                                        | <u>20/12</u>                                                        |
| Time:                                    |                                                                                                                                                | <u>8pm</u>                                                          | <u>2pm</u>                                                          | <u>2pm</u>                                                          | <u>8pm</u>                                                          | <u>8am</u>                                                          | <u>2pm</u>                                                          |

## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|                                          |                                                           |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| SITUATION                                | Diagnosis:<br><i>EL-LSCS</i>                              |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |
|                                          |                                                           |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |
| BACKGROUND                               | Area                                                      | <i>20/7/26 E2</i>                                                   | <i>20/7/26 M1</i>                                                                                                                   | <i>21/7/26 MG</i>                                                   |                                                                     |                                                                     |
|                                          | Shift Time                                                |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |
|                                          | Medical Condition<br>(Any special condition to be noted): | <i>LSCS</i>                                                         | <i>LSCS</i>                                                                                                                         | <i>LSCS</i>                                                         |                                                                     |                                                                     |
| ASSESSMENT                               | Allergy:                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Vital Signs:                                              | Temp: <i>98.1°F</i>                                                 | <i>98.3°F</i>                                                                                                                       | <i>98.4°F</i>                                                       |                                                                     |                                                                     |
|                                          | Res:                                                      | <i>20b/m</i>                                                        | <i>20b/m</i>                                                                                                                        | <i>20b/m</i>                                                        |                                                                     |                                                                     |
|                                          | SpO <sub>2</sub> :                                        | <i>99%</i>                                                          | <i>99b/m</i>                                                                                                                        | <i>99b/m</i>                                                        |                                                                     |                                                                     |
|                                          | Pulse:                                                    | <i>86b/m</i>                                                        | <i>82b/m</i>                                                                                                                        | <i>86b/m</i>                                                        |                                                                     |                                                                     |
|                                          | BP:                                                       | <i>104/70</i>                                                       | <i>103/62</i>                                                                                                                       | <i>110/72</i>                                                       |                                                                     |                                                                     |
|                                          | Fall Risk Score:                                          | <i>0</i>                                                            | <i>0</i>                                                                                                                            | <i>0</i>                                                            |                                                                     |                                                                     |
| Recommendations                          | Pain Score:                                               | <i>0</i>                                                            | <i>0</i>                                                                                                                            | <i>0</i>                                                            |                                                                     |                                                                     |
|                                          | Safety Needs:                                             | <i>Yes</i>                                                          | <i>Yes</i>                                                                                                                          | <i>Yes</i>                                                          |                                                                     |                                                                     |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Others Specify:                                           | <i>-</i>                                                            | <i>-</i>                                                                                                                            | <i>-</i>                                                            |                                                                     |                                                                     |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Other Special Orders / Medications:      |                                                           | <i>-</i>                                                            | <i>-</i>                                                                                                                            | <i>-</i>                                                            |                                                                     |                                                                     |
| Post Operative Procedure Special Orders: |                                                           | <i>-</i>                                                            | <i>-</i>                                                                                                                            | <i>-</i>                                                            |                                                                     |                                                                     |
| Handed Over By Name :                    |                                                           | <i>Supriya</i>                                                      | <i>Summa</i>                                                                                                                        | <i>Mouthali</i>                                                     |                                                                     |                                                                     |
| Signature :                              |                                                           | <i>[Signature]</i>                                                  | <i>[Signature]</i>                                                                                                                  | <i>[Signature]</i>                                                  |                                                                     |                                                                     |
| Date:                                    |                                                           | <i>20/7/26</i>                                                      | <i>21/7/26</i>                                                                                                                      | <i>21/7/26</i>                                                      |                                                                     |                                                                     |
| Time:                                    |                                                           | <i>8PM</i>                                                          | <i>8PM</i>                                                                                                                          | <i>8PM</i>                                                          |                                                                     |                                                                     |
| Taken Over By Name :                     |                                                           | <i>Summa</i>                                                        | <i>Mouthali</i>                                                                                                                     |                                                                     |                                                                     |                                                                     |
| Signature :                              |                                                           | <i>[Signature]</i>                                                  | <i>[Signature]</i>                                                                                                                  |                                                                     |                                                                     |                                                                     |
| Date:                                    |                                                           | <i>20/7/26</i>                                                      | <i>21/7/26</i>                                                                                                                      |                                                                     |                                                                     |                                                                     |
| Time:                                    |                                                           | <i>8PM</i>                                                          | <i>8PM</i>                                                                                                                          |                                                                     |                                                                     |                                                                     |



BAH-00520821 IP26-00006876  
 Mrs SHIKHA MANTRI  
 27-12-1995 30 Y 6 M 21 D (F)  
 Dr. SWAPNA SAMUDRALA



## DRUG CHART

Date of Admission: 18/7/2021 Drug Allergies: Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).  
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.  
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.  
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.  
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.  
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time  
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

### SOS / PRN (As Required Medication)

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name





REGULAR PRESCRIPTIONS

Weight. 71kg Ward. ....

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

|                                                           |             |                  |                    |                    |                     |
|-----------------------------------------------------------|-------------|------------------|--------------------|--------------------|---------------------|
| <b>DRUG :</b> INJ CEFOTAXIME                              |             |                  |                    | Date<br>Time       | 18/7                |
| Dose<br>1g                                                | Route<br>IV | Frequency<br>BD  | Start Date<br>18/7 | 10:30 AM           |                     |
| Name & Signature of the Doctor<br>Starting the Drugs:     |             |                  |                    | STOP<br>Dr. Naveen |                     |
| Additional Instructions: (test done)                      |             |                  |                    |                    |                     |
| Daily Doctor's Endorsement by a Sign                      |             |                  |                    |                    |                     |
| <b>DRUG :</b> PARACETAMOL                                 |             |                  |                    | Date<br>Time       | 18/7 9/7            |
| Dose<br>1gm                                               | Route<br>IV | Frequency<br>TID | Start Date<br>18/7 | 7 AM               | 3 PM                |
| Name & Signature of the Doctor<br>Starting the Drugs:     |             |                  |                    | 11 PM              |                     |
| Additional Instructions: IV FOR 24 HRS FOLLOWED BY ORALS. |             |                  |                    | Dr. Dina           |                     |
| Daily Doctor's Endorsement by a Sign                      |             |                  |                    |                    |                     |
| <b>DRUG :</b> DICLOFENAC                                  |             |                  |                    | Date<br>Time       | 18/7 19/7 20/7 21/7 |
| Dose<br>75mg                                              | Route<br>IV | Frequency<br>BD  | Start Date<br>18/7 | 10 AM              | 10 PM               |
| Name & Signature of the Doctor<br>Starting the Drugs:     |             |                  |                    | 10 PM              |                     |
| Additional Instructions: SLOW IV IN 100MLNS.              |             |                  |                    | Dr. Dina           |                     |
| Daily Doctor's Endorsement by a Sign                      |             |                  |                    |                    |                     |
| <b>DRUG :</b> INJ MAGNEX FORTE                            |             |                  |                    | Date<br>Time       | 18/7 19/7 20/7      |
| Dose<br>1.5gm                                             | Route<br>IV | Frequency<br>BD  | Start Date<br>18/7 | 10 AM              | 10 PM               |
| Name & Signature of the Doctor<br>Starting the Drugs:     |             |                  |                    | 10 PM              |                     |
| Additional Instructions: SULBACTAM + CEFOPERAZONE         |             |                  |                    | Dr. Dina           |                     |
| Daily Doctor's Endorsement by a Sign                      |             |                  |                    |                    |                     |



Sheet No: .....

# REGULAR PRESCRIPTIONS

Weight 7.5kg Ward .....

|                                                                      |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------|-------------|------------------|-------------------|------------------|---------|----------|---------|---------|----------|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG : INS. METRONIDAZOLE</b>                                     |             |                  |                   | Date<br>Time     | 18/7    | 19/7     | 20/7    | 21/7    |          |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>500mg                                                        | Route<br>IV | Frequency<br>TID | Start Dt.<br>18/7 | 7<br>Am          | 3<br>Pm | 11<br>Pm | 7<br>Am | 3<br>Pm | 11<br>Pm |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Naveena |             |                  |                   | STOP Dr. Naveena |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>FOR 48 HRS                               |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : INS. PANTOPRAZOLE</b>                                      |             |                  |                   | Date<br>Time     | 18/7    | 19/7     | 20/7    | 21/7    |          |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>40mg                                                         | Route<br>IV | Frequency<br>BD  | Start Dt.<br>18/7 | 8<br>Am          | 6<br>Pm |          | 8<br>Am | 6<br>Pm |          |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Naveena |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>FOR 48 HRS                               |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : INS. TRANEXAMIC ACID</b>                                   |             |                  |                   | Date<br>Time     | 18/7    | 19/7     |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>1gm                                                          | Route<br>IV | Frequency<br>TID | Start Dt.<br>18/7 | 7<br>Am          | 3<br>Pm | 11<br>Pm |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Naveena |             |                  |                   | stop Dr. Naveena |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>FOR 24 HRS                               |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : PARACETAMOL</b>                                            |             |                  |                   | Date<br>Time     | 19/7    | 20/7     | 21/7    |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>1g                                                           | Route<br>PO | Frequency<br>TID | Start Dt.<br>19/7 | 7<br>Am          | 3<br>Pm | 11<br>Pm |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Dina    |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                             |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |             |                  |                   |                  |         |          |         |         |          |  |  |  |  |  |  |  |  |  |  |  |



DR. SWAPNA SAMEDHON



## REGULAR PRESCRIPTIONS

Weight ..... Ward

Docu. No. : RCH /FRM / CLINICAL / 108





| Date > Time                    |           | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|-----------|------------|------------|------------|------------|
| DRUG :                         | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Route                          | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Start Date                     | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Name & Signature of the Doctor | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Additional Instructions:       | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |

| Date > Time                    |           | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|-----------|------------|------------|------------|------------|
| DRUG :                         | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Route                          | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Start Date                     | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Name & Signature of the Doctor | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |
| Additional Instructions:       | Dose      |            |            |            |            |
|                                | Dr. Sign. |            |            |            |            |

## STAT / ONCE ONLY DRUGS

| Date | Time     | Medication             | Dosage & Other Instructions | Route      | Signature   | Nurses      |
|------|----------|------------------------|-----------------------------|------------|-------------|-------------|
| 18/7 | 10-30 AM | INJ PANTOPRAZOLE       | 40mg                        | IV         | [Signature] | [Signature] |
| 18/7 | 10-30 AM | INJ METOCLOPRAMIDE     | 10mg                        | IV         | [Signature] | [Signature] |
| 18/7 | 1245pm   | DICLOFENAC             | 100mg                       | PR         | [Signature] | [Signature] |
| 18/7 | 1045am   | TRANEXAMIC ACID        | 1gm                         | IV         | [Signature] | [Signature] |
| 18/7 | 1215pm   | HYDROCORTISONE         | 100mg                       | IV         | [Signature] | [Signature] |
| 18/7 | 1245pm   | LIGNOCAINE             | 5%                          | SKIN PATCH | [Signature] | [Signature] |
| 18/7 | 1245pm   | LIGNOCAINE             | 5%                          | SKIN PATCH | [Signature] | [Signature] |
| 19/7 | 9pm      | INJ METOCLOPRAMIDE     | 10mg                        | IV         | [Signature] | [Signature] |
| 19/7 | 10pm     | DULCOLAX SUPPOSITORIES | 2                           | PR         | [Signature] | [Signature] |



# I.V. FLUIDS CHART

Weight: 55 kg Ward: .....

Signature

VERIFIED BY : Name

| Date | Time       | Composition of I.V. Fluid<br>(If infusion, mention ml/hr = Mcg/kg/min. etc) | Route | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign |
|------|------------|-----------------------------------------------------------------------------|-------|--------------------|----------------|---------------|---------------------|----------------|---------------|
| 18/7 | 8:30 PM    | RINGER<br>LACTATE                                                           | IV    | 100<br>ml/hr       | 1              |               | 18/7                |                |               |
| 18/7 | 1045<br>am | RINGER<br>LACTATE                                                           | IV    | 500                |                |               | 18/7                |                |               |
| 18/7 | 1045<br>am | RINGER<br>LACTATE<br>+ 6u OXYTOCIN                                          | IV    | 500                |                |               | 18/7                |                |               |
| 18/7 | 1115am     | RINGER<br>LACTATE                                                           | IV    | 1000               |                |               | 18/7                |                |               |
| 18/7 | 1115<br>am | RINGER LACTATE +<br>20u OXYTOCIN                                            | IV    | 100                |                |               | 18/7                |                |               |
| 18/7 | 1245<br>pm | PRBC<br>BAG # 1453<br>(CHECKED)                                             | IV    | 25<br>+<br>100     |                |               | 18/7                |                |               |
| 18/7 | 6<br>pm    | RINGER<br>LACTATE                                                           | IV    | 1000ml<br>hr       |                |               | 19/7                |                |               |
| 19/7 | 2AM        | RINGER LACTATE                                                              | IV    | 1000ml<br>hr       |                |               | 19/7                |                |               |
| 19/7 | 8AM        | RINGER<br>LACTATE                                                           | IV    | 1000ml<br>hr       |                |               |                     |                |               |
| 20/7 | 2PM        | RINGER<br>LACTATE                                                           | IV    | 1000ml<br>hr       |                |               |                     |                |               |

Stop

Start





## CAESAREAN SECTION OPERATIVE NOTES

|                                                    |                                                                                     |
|----------------------------------------------------|-------------------------------------------------------------------------------------|
| Surgeon's Name: <u>Dr Swapna Samudrala</u>         | Date of Delivery: <u>18/7/2026</u>                                                  |
| Assistant Surgeon: <u>Dr JV Reddy / Dr Naveena</u> | Time of Delivery: <u>11:02 am</u>                                                   |
| Anaesthetist's Name: <u>Dr Samir</u>               | Gender of Baby: <u>Male</u>                                                         |
| Type of Anaesthesia: <u>Spinal</u>                 | Weight of Baby: <u>2.900 Kg.</u>                                                    |
| Neonatologist: <u>Dr. Sushanth</u>                 | AGPAR Score: <u>7, 8</u>                                                            |
| Scrub Nurse: <u>Sandhya / Natasha</u>              | NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

Pre-Operative Diagnosis: Primi with 37w 5days POG with Fibroid Complication. preg c I+CP for elective LSCS + myo mectom

☒ Elective ☐ Emergency Indication: Multiple large Fibroids

Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: ..... Knife to rectus: .....

CTG Description: Reactive.

If there was a delay give the reasons: .....

Surgical Procedure: Elective lower segment caesarean section + Myomectomy

Post Operative Diagnosis: P14 & POD - 0

Peri-Operative Complications:

Amount of Blood Loss: 400-500ml 1200ml Blood Transfused (in ML): 1 @ PRBC on flow

Name and Number of Surgical Specimen sent for examination: 6 Subserosal fibroid.



# Examination Findings when Appropriate:

Presentation: ☒ Cephalic ☐ Breech ☐ Other .....

5th Palpable: 3/5

Station: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Caput: ☐ + ☐ ++ ☐ +++

Bladder Catheterized: ☒ Yes ☐ No

Cervical Dilatation: closed cm

Fetal Position: .....

Moulding: ☒ None ☐ + ☐ ++ ☐ +++

Meconium: ☒ None ☐ + ☐ ++ ☐ +++

Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinned out ☐ Ruptured ☒ No Scar

Incision Through Placenta: ☐ Yes ☒ No

Delivery of head: ☐ Manual ☒ Forceps

Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: normal Cord around the neck ☒ Yes ☐ No

Appearance of placenta: normal Cavity explored ☒ Yes ☐ No

Uterus, tubes and ovaries: ☐ Normal ☐ Not Normal Sterilization: ☐ Yes ☐ No

Uterine Closure: ☐ One Layer ☒ Two Layers

Peritoneal Closure: ☐ Pelvic ☒ Abdominal ☐ None

Sheath Closure: ☐ Yes ☒ No

Fat Closure: ☒ Yes ☐ No

Skin Closure: ☒ Subcuticular ☐ Mattress

Vaginal Evacuated ☐ Yes ☐ No

Drain: ☒ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

Catheter: ☒ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

Swap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☐ No

Intra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☐ No

Post-Operative Notes: Adv

- NBM till further Order

- IVF / Analgesic / Thromboprophylaxis - 4x100

- Drugs as Charted

- 9AM / 20 / 210 Drain Output Charted

- W/F bleeding P/V

- CBP TIM 6am

- Jayson See

Doctor Name: .....

Doctor Signature: Jayson

Date & Time: .....

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna  
Asst. Surgeon : Dr. Naveen  
Anaesthetist : Dr. Samir  
Scrub Nurse : Sr. Sandhya

BAH-00520821 IP26-00006876  
Mrs SHIKHA MANTRI  
27-12-1995 30 Y 6 M 21 D (F)  
Dr. SWAPNA SAMUDRALA



Date : 18/7/26 In-time : 10:45 AM Out-time : 12:45 PM

Age : 30 Yrs Gender : F

Y Name : EL. LSCS. T. myomectomy

Rainbow  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## Before Induction of Anaesthesia >>

| SIGN IN                                                                  |                                                                                                 | Time: <u>10:45 AM</u> |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------|
| <b>Patient Has Confirmed</b>                                             |                                                                                                 |                       |
| Identity                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| Site                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| Procedure                                                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| Consent                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| <b>Site Marked</b>                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                       |
| <b>Anaesthesia Safety Check Completed</b>                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| <b>Does Patient have a:</b>                                              |                                                                                                 |                       |
| Known Allergy?                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                       |
| <b>Difficult Airway / Aspiration Risk?</b>                               |                                                                                                 |                       |
| Yes, & Equipment / Assistance Available                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                                 |                       |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Blood Units Reserved                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                                 |                       |
|                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Signature : <u>[Signature]</u>                                           |                                                                                                 |                       |
| Name : <u>[Name]</u>                                                     |                                                                                                 |                       |

## Before Skin Incision >>

| TIME OUT                                                                                                                                                                                                              |                                                                     | Time: <u>10:57 AM</u> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                       |                                                                     |                       |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>                                                                                                                                                   |                                                                     |                       |
| Correct Patient (Check ID Band)                                                                                                                                                                                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                       |
| Correct Site                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                       |
| Correct Procedure                                                                                                                                                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                       |
| <b>Anticipated Critical Events</b>                                                                                                                                                                                    |                                                                     |                       |
| <b>Surgeon Reviews:</b>                                                                                                                                                                                               |                                                                     |                       |
| What are the Critical or Unexpected Steps, Operative Duration, <u>1 1/2 hr</u> Anticipated Blood Loss? <u>140-150</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                                                                     |                       |
| <b>Anaesthesia Team Reviews:</b>                                                                                                                                                                                      |                                                                     |                       |
| Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA                                                                              |                                                                     |                       |
| <b>Nursing Team Reviews:</b>                                                                                                                                                                                          |                                                                     |                       |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA               |                                                                     |                       |
| <b>Is Essential Imaging Displayed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                                |                                                                     |                       |
| Signature : <u>[Signature]</u>                                                                                                                                                                                        |                                                                     |                       |
| Name : <u>[Name]</u>                                                                                                                                                                                                  |                                                                     |                       |

## Before Patient Leaves Operating Room

| SIGN OUT                                                                                                                                   |                                                                                                 | Time: <u>10:58 AM</u> |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                                                                                              |                                                                                                 |                       |
| The Name of the Procedure Recorded                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| The Specimen is Labelled (including patient name)                                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Whether there are any Equipment Problems to be addressed                                                                                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                                                                                 |                                                                                                 |                       |
| What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                 |                       |
| Signature : <u>[Signature]</u>                                                                                                             |                                                                                                 |                       |
| Name : <u>[Name]</u>                                                                                                                       |                                                                                                 |                       |



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                                            |                                  |                                                                                                                                                                            |                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| Patient Name & UHID No.<br><br>BAH-00520821      IP26-00006876<br>Mrs SHIKHA MANTRI<br>27-12-1995      30 Y 6 M 21 D      (F)<br>Dr. SWAPNA SAMUDRALA<br> |                                  | Date & Time of Admission<br><br>18/7/26 @ 8:30 AM                                                                                                                          | Date & Time of Transfer Order<br><br>18/7/26 @ 12:45 PM |
|                                                                                                                                                                                                                                            |                                  | Transfer Ordered by<br><br>Dr. Samir                                                                                                                                       | Reason for Transfer<br><br>Observation                  |
| From Unit<br><br>OT                                                                                                                                                                                                                        | To Unit<br><br>Pre-Post          | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                            |                                                         |
| Number of Sheets in Clinical File                                                                                                                                                                                                          | Number of Imaging Films<br><br>- | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>If yes, what ? |                                                         |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                                          |                                  |                                                                                                                                                                            |                                                         |
| Sl.No.                                                                                                                                                                                                                                     | Item Name                        | Quantity                                                                                                                                                                   |                                                         |
| 1.                                                                                                                                                                                                                                         | RL                               | -                                                                                                                                                                          |                                                         |
| 2.                                                                                                                                                                                                                                         |                                  |                                                                                                                                                                            |                                                         |
| 3.                                                                                                                                                                                                                                         |                                  |                                                                                                                                                                            |                                                         |
| 4.                                                                                                                                                                                                                                         |                                  |                                                                                                                                                                            |                                                         |
| 5.                                                                                                                                                                                                                                         |                                  |                                                                                                                                                                            |                                                         |
| Shifting Summary / Notes Written by Doctor :      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                                      |                                  |                                                                                                                                                                            |                                                         |
| Name & Signature of Person who is Transferring<br><br>Sr. Natasha                                                                                                                                                                          |                                  | Name of Person Ordered Transfer<br><br>Dr. Samir                                                                                                                           |                                                         |
| Patient & Clinical Records Received by :                                                                                                                                                                                                   |                                  |                                                                                                                                                                            |                                                         |
| Date & Time of Patient Received :                                                                                                                                                                                                          |                                  |                                                                                                                                                                            |                                                         |

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : MRS SHIKHA MANTRI Gender: ☐ Male ☒ Female Age : 30 YRS  
UHID No : BAH - 00520821 Date : 18/7/2026

## Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

MYOMECTOMY.

upon

MRS SHIKHA MANTRI (Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery / procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Haemorrhage, Need for Blood and Blood products  
transfusion, Need for Multidisciplinary management

## My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Swapna Samudhala

## Consentee :

Signature : [Signature]

Name : MRS. Shikha. Mantri

Date & Time : 18/7/2026 @ 10:15am

## Witness :

Signature : [Signature]

Name : Usha...

Date & Time : 18/7/26 @ 10:15 Am

Docu. No. : RCH / FRM / CLINICAL / 027

## Patient Attendant :

Signature : [Signature]

Name : Siddharth Mantri

Relationship with Patient : Husband

Date & Time : 18/7/2026 @ 10:15am

## Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Naveena

Date & Time : 18/7/2026 @ 10:15am



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Ms Shikha Mathur Gender: ☐ Male ☒ Female Age : 30y  
UHID No : BAH-00520821 Date : 18/7/2022

## Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

ELECTIVE LOWER SEGMENT CAESAREAN SECTION  
+/- MYOMECTOMY upon

(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Bleeding, Infection, Inadvertent Injury to Bowel Bladder or Blood vessel  
Chances of Blood transfusion or Blood Products transfusion, need for  
Stepwise devascularization.

## My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Sneha Samuelkale

## Consentee :

Signature : [Signature]

Name : Ms Shikha Mathur

Date & Time : 18/7/26 @ 9:00am

## Witness :

Signature : [Signature]

Name : Chauhan Kale

Date & Time : 18/7/26 @ 9pm

Docu. No. : RCH / FRM / CLINICAL / 027

## Patient Attendant :

Signature : [Signature]

Name : Siddharth Mathur

Relationship with Patient: Husband

Date & Time : 18/7/26 @ 9:00am

## Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Moudela

Date & Time : 18/7/26 @ 9:00am

# **CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE**

Patient Name : Ms. Shikha Mantu Age : 30 Gender : Male ☐ Female ☒  
UHID NO: BAH-1520821 Surgeon Name: Dr. Anupma Samudhala  
Anaesthesiologist : Dr. Samir Chayath  
Operative procedure planned : hscs +/- myomectomy

## **PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA**

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

**Specific High Risk (s) :** The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart disease      ☐ Hypertension      ☐ Diabetes mellitus      ☐ Renal failure  
☐ Hepatic disorders      ☐ Shock      ☐ Multiple organ failure      ☐ Polytrauma / Renal Tubular Acidosis  
☐ Incapacitating Chronic Obstructive Pulmonary Disease  
☒ Others : Bleeding / Need for blood products / transfusions etc,

Comments : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

## **DECLARATION BY PATIENT / GUARDIAN / PROXY**

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me my patient  
..... the above mentioned operation / Diagnostic / Therapeutic procedures

I authorize and give consent for anaesthesia ( ☒ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.



I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☒ Yes ☐ No

#### DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : \_\_\_\_\_

Name : Mrs. Shikha Mantri

Relationship with Patient : self

Date & Time : 18/7 at 1030am

Witness :

Signature : \_\_\_\_\_

Name : Mr. Siddharth Mantri

Date & Time : 18/7 at 1030am

Doctor (who is taking the consent) :

Signature : \_\_\_\_\_

Name : Dr. Ranvi Bhatnagar

Date & Time : 18/7 at 1030am

92461 60961

# Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

**Rainbow Children's Hospital**  
It takes a lot to treat the little.

**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Name: Mrs. Shikha Mantri Age: 30y Sex: Female UHID.No: BAH-520821

Date: 15/7 Time: 12:00pm Proposed Operation: LSCS & Myomectomy

Diagnosis: primi at 37<sup>+</sup>2 + fibroid complicating pregnancy

B.P / CRT: 109/53 H.R: 75 Weight: 75kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

## Laboratory Data:

Hgb: noted in chart Glucose: Protein: HIV: X-Ray:  
PCV: Urea: Alb: HBS Ag: ECG:  
WBC: Creat: Total Bill: HCV: 2D Echo:  
Plate: Na: Dir. Bill: Blood group: O pos Stress/Angio:  
PT: K: LDH: T3 Other:  
PTT: Ca++: Alk phos: T4  
INR: Mg++: Amylase: TSH  
Cl-: SGOT/SGPT:

Allergies: NADA

placenta - past 2-3 cm from os.

## Medical History: CVS: 1

RESP: No significant medical history. Diabetes:

CNS: Regular ANCS - itching → more acids → (N) now.

Renal: occasional vertigo → lasting for few seconds.

Hepatic / GE: No jaundice Physical Activity: good. Active

Others:

Past Anaesthetic History: nil → multiple fibroids

Physical Exam: coherent 6x4x7 fundal subserosal  
4x2-3x Ant wall sub seral  
101x7x9 post wall.

Airway: MP 1 2 3 4 Mouth Opening: adq Mentohyoid Distance: 3cm Neck: (N) Teeth: intact

Lungs: /clear

Heart:

CNS:

Pregnant: ☐ Yes ☒ No ☐ NA Venous Access Site: Peripheral X2 Spine Exam for regional: midline

Anaesthetic Plan: ☐ MAC ☒ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

| CURRENT MEDICATIONS | DOSAGE           |
|---------------------|------------------|
| <u>VDILIV 300mg</u> | <u>1 - x - 1</u> |
|                     |                  |
|                     |                  |
|                     |                  |

## Pre-Operative Instructions:

- DVT Prophylaxis: Water / ORS 2 Hours
- NIL ORAL: Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: as per to be done  
CBP to be done

4am ← 6am → 10am  
8am 2hrs  
WATER  
ORS

Signature: [Signature] Name: Dr. Lamin Inayati









## POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Anushe D Time Received : 1pm Time Discharged : 2pm

|                                                                                                                                                                                             |                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>SPO <sub>2</sub> | 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>SPO <sub>2</sub> | IV Cannula Site : <u>(L)</u><br><input type="checkbox"/> O <sub>2</sub> Mask <input type="checkbox"/> Nasal Prongs<br><input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece<br><input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                             |                                                                                                                                                                                             | Vomiting : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>NG Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Drain : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Urinary Catheter : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Chest Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Nil Oral : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>IV Fluids : <u>RL on flow</u><br>Oral Feeds : <u>NBM</u> |

| POST ANAESTHESIA SCORE<br>(Modified Aldrete Score) |     | MINUTES       |    |    | OUT | SCORING INTERPRETATION                                                                                                                               |
|----------------------------------------------------|-----|---------------|----|----|-----|------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                    |     | IN            | 30 | 60 | 90  |                                                                                                                                                      |
| Able to move 4 extremities voluntary or on command | = 2 | ACTIVITY      | 1  | 2  | 2   | A Minimum Total Score of 8 is Required for Discharge<br><br>Exceptions to this, are to be explained in the space below by the Discharging Physician: |
| Able to move 2 extremities voluntary or on command | = 1 |               |    |    |     |                                                                                                                                                      |
| Able to move 0 extremities voluntary or on command | = 0 |               |    |    |     |                                                                                                                                                      |
| Able to deep breathe & cough freely                | = 2 | RESPIRATION   | 2  | 2  | 2   |                                                                                                                                                      |
| Dyspnea or limited breathing                       | = 1 |               |    |    |     |                                                                                                                                                      |
| Apneic                                             | = 0 |               |    |    |     |                                                                                                                                                      |
| BP ± 20 of Pre Anaesthetic level                   | = 2 | CIRCULATION   | 2  | 2  | 2   |                                                                                                                                                      |
| BP ± 20-50 of Pre Anaesthetic level                | = 1 |               |    |    |     |                                                                                                                                                      |
| BP ± 50 of Pre Anaesthetic level                   | = 0 |               |    |    |     |                                                                                                                                                      |
| Fully awake                                        | = 2 | CONSCIOUSNESS | 2  | 2  | 2   |                                                                                                                                                      |
| Arousable on calling                               | = 1 |               |    |    |     |                                                                                                                                                      |
| Not responding                                     | = 0 |               |    |    |     |                                                                                                                                                      |
| Pink                                               | = 2 | COLOR         | 2  | 2  | 2   |                                                                                                                                                      |
| Pale, dusky, blotchy, jaundiced, other             | = 1 |               |    |    |     |                                                                                                                                                      |
| Cyanotic                                           | = 0 |               |    |    |     |                                                                                                                                                      |
| TOTAL                                              |     |               | 9  | 10 | 10  |                                                                                                                                                      |

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time   | Pain Score | Intervention | Signature       |
|------|--------|------------|--------------|-----------------|
| 18/7 | 1pm    | 0/10       | No pain      | <u>Anushe D</u> |
| 18/7 | 3:30pm | 0/10       | No pain      |                 |
| 18/7 | 2pm    | 0/10       | No pain      |                 |
| 19/7 | 2:30pm | 0/10       | No pain      |                 |

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : SARAJ

Anaesthesiologist Signature: [Signature]

Date & Time: 19/7/26 @ 2pm

PACU Nurse Name : Chunabakale

PACU Nurse Signature: CT

Date & Time: 19/7/26 @ 2pm

### Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
  - Every 2 hours for first 24 hours
  - After 24 hours every 4 hours
  - Prior to pain relieving intervention
  - Within 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 305

Date & Time: 19/7/26

Patient Sticker

Department of Anaesthesiology

## EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space : ..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

| Time | Infusion Rate<br>(ml/hr) | Bolus (ml) | Level |       | Maternal |       | FHR | Comments |
|------|--------------------------|------------|-------|-------|----------|-------|-----|----------|
|      |                          |            | Left  | Right | BP       | Pulse |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |
|      |                          |            |       |       |          |       |     |          |

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....



BAH-00520821 IP26-00006876  
Mrs SHIKHA MANTRI  
27-12-1995 30 Y 6 M 21 D (F)  
Dr. SWAPNA SAMUDRALA



## JD TRANSFUSION

Rainbow®  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Name: Mrs. Shikha Mantri Age: 30yr Gender: Male ☐ Female ☒  
UHID.No: BAH-00520821 Date: 18/7/2026

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets  
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood  
☐ Albumin ☐ Red Blood Cell ☐ Others .....

I Mrs. Shikha Mantri hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: Siddhant

Signature: [Signature]

Name: Siddhant Mantri

Name: Dr Samir Inayatkh

Date & Time: 18/7/26 @ 12:50pm

Date & Time: 18/7 12:50pm

Witness

Signature: Siddhant

Name: .....

Date & Time: 18/7/26 @ 12:50pm



# PATIENT TRANSFER FORM

|                                                                                                                                                                                              |                                             |                                                                                                                                                                 |                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| BAH-00520821 IP26-00006876<br>Mrs SHIKHA MANTRI<br>27-12-1995 30 Y 6 M 21 D (F)<br>Dr. SWAPNA SAMUDRALA<br> |                                             | Date & Time of Admission<br><b>18/7/26 @ 8:30 AM</b>                                                                                                            | Date & Time of Transfer Order<br><b>18/7/26 @ 10:30 AM</b> |
|                                                                                                                                                                                              |                                             | Transfer Ordered by<br><b>Dr. Naveena</b>                                                                                                                       | Reason for Transfer<br><b>EL NGU</b>                       |
| From Unit<br><b>pre-part</b>                                                                                                                                                                 | To Unit<br><b>O-T</b>                       | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                 |                                                            |
| Number of Sheets in Clinical File<br><b>25</b>                                                                                                                                               | Number of Imaging Films<br><b>NST - (1)</b> | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                            |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                            |                                             |                                                                                                                                                                 |                                                            |
| Sl.No.                                                                                                                                                                                       | Item Name                                   | Quantity                                                                                                                                                        |                                                            |
| 1.                                                                                                                                                                                           | <b>RL</b>                                   | <b>10</b>                                                                                                                                                       |                                                            |
| 2.                                                                                                                                                                                           |                                             |                                                                                                                                                                 |                                                            |
| 3.                                                                                                                                                                                           |                                             |                                                                                                                                                                 |                                                            |
| 4.                                                                                                                                                                                           |                                             |                                                                                                                                                                 |                                                            |
| 5.                                                                                                                                                                                           |                                             |                                                                                                                                                                 |                                                            |
| Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                        |                                             |                                                                                                                                                                 |                                                            |
| Name & Signature of Person who is Transferring<br><b>Chauhan Kalya</b>                                                                                                                       |                                             | Name of Person Ordered Transfer<br><b>Dr. Naveena</b>                                                                                                           |                                                            |
| Patient & Clinical Records Received by :<br><b>Kaunwar</b><br><b>18/7/26</b>                                                                                                                 |                                             |                                                                                                                                                                 |                                                            |
| Date & Time of Patient Received :                                                                                                                                                            |                                             |                                                                                                                                                                 |                                                            |

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready





10 PRBE

## BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 18/7/2026 Time: 12:52 PM

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: 1453

Blood Bank Issue No: 1453 Date of Collection: 16/7/26 Date of Expiry: 27/8/26

Date & Time of Starting Transfusion: 18/7/26 / 12:50 PM Planned duration of Transfusion: 1-3 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: U. Pallavi Nurse 2: S. Srinivasan

Before starting transfusion vitals: Temp: 98 HR 72 RR: 100 BP: 105/72 SpO<sub>2</sub> 99

### PLEASE MONITOR THE FOLLOWING:

| Date    | Time              | HR | Temperature | Blood Pressure | SpO <sub>2</sub> | Any Rash | Any Rigors | Any Breathlessness | Any Other Problem |
|---------|-------------------|----|-------------|----------------|------------------|----------|------------|--------------------|-------------------|
| 18/7/26 | 4 PM<br>15 Min    | 72 | 98.6°F      | 105/72         | 100              | NO       | NO         | NO                 |                   |
| 18/7/26 | 5:30 PM<br>15 Min | 62 | 98.7        | 102/78         | 99%              | NO       | NO         | NO                 |                   |
| 18/7/26 | 2 PM<br>30 Min    | 60 | 98.8        | 112/62         | 99%              | -        | -          | -                  | -                 |
| 18/7/26 | 8:30 PM<br>30 Min | 65 | 98.5        | 116/72         | 99%              | -        | -          | -                  | -                 |
| 18/7/26 | 3 PM<br>30 Min    | 80 | 97.6°F      | 110/70         | 99%              | -        | -          | -                  | -                 |
| 18/7/26 | 3:30 PM<br>1 Hr   | 70 | 97.4°F      | 100/70         | 99%              | -        | -          | -                  | -                 |
| 18/7/26 | 4 PM<br>1 Hr      | 69 | 97.6°F      | 106/78         | 99%              | -        | -          | -                  | -                 |
| 18/7/26 | 4:30 PM           | 59 | 97°F        | 108/78         | 100%             | -        | -          | -                  | -                 |
| 18/7/26 | 5:30 PM           | 62 | 97.7        | 112/62         | 100%             |          |            |                    |                   |

Comments: No any complications during the Blood Transfusion.

Name of the Incharge-Nurse: U. Pallavi

Name of the Nurse: Anshu

Signature of the Incharge-Nurse: U. Pallavi

Signature of the Nurse: Anshu

Date & Time: 18/7/26 12:52 PM

Date & Time: 18/7/26 12:52 PM

Phone : 8790221175 , 8341711775

## SURYA BLOOD CENTRE

(A unit of Telangana Development Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

**PACKED RED CELLS I.P. 220-280 ml**

Anticoagulant : CPDA Solution U.S.P. 49 ml / 63ml

Prepared from a **VOLUNTARY DONOR / REPLACEMENT**

Blood Group.: **'O'** Rh (D) Type: **POSITIVE**

Blood Bag No.: **1453** Volume: **250ml** Collection Date: **16/7/26**

Tested Date: **16/7/26** Expiry Date: **27/8/26**

**Tested and Found Negative for HIV I & II antibodies, HBsAg, HCV antibodies, VDRL & Malaria Parasites.**

- CAUTION**
- 1) Do not use if there is any visible evidence of deterioration like haemolysis, clotting & discolourisation.
  - 2) Storage temperature 2°-6° C.
  - 3) Bring the Blood bag to room temperature before transfusion.
  - 4) Do not keep the Blood Bag in De-Freezer compartment in refrigerator.
  - 5) Shake gently before use. 6) Administer without warming.
  - 7) Transfuse under medical supervision only.
  - 8) Do not add any medicine to the blood.
  - 9) Use a fresh, sterile pyrogen free disposable transfusion set with filter.
  - 10) Do not dispense with out prescription.
  - 11) Check Blood Group & Rh Type on label and Recipient Group & Rh type before administration.
  - 12) Cross match before use. 13) Appropriate compatible, cross matched blood without a typical antibody in recipient should be used.
  - 14) If Hemolysin is present in ~~D~~ Negative blood units it should be transfused to the same blood group recipient only.

**Please Note :** It is advised that this Blood Bag which is stored in our Blood Centre refrigerator at ideal temperature must be transfused immediately without further storing it. This Blood Bank bears no responsibility if this bag is further stored with-





## OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 18/12/26 Time of Arrival: 8:30 AM Time Seen by Nurse: 8:30 AM

1) **Level of Consciousness:** ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

2) **Chief Complaint (Reason for Visit):** (Circle the item as appropriate)

☐ Severe Pain / Moderate Pain

☐ Preterm rupture of Membranes / Leaking Water PV

☐ Bleeding PV: Slight / Heavy

☐ Preterm Labor/ Labor

☐ Decreased Fetal Movement

☐ Spontaneous Rupture of Membrane / Leaking Water PV

☐ No Fetal Movement

☐ Other Reason: .....

3) **Vital Signs:** Temperature: 98.4 Pulse: 92bnt RR: 20bnt SpO<sub>2</sub>: 98% BP: 110/80 Weight: .....

4) **Gestational Criteria:**

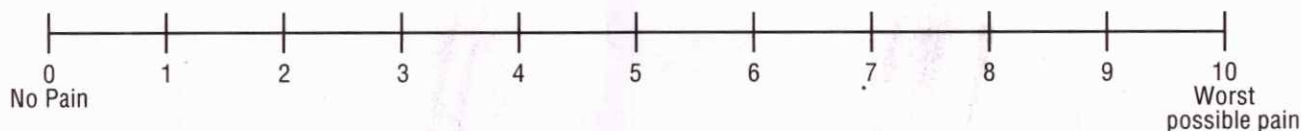
|          |     |   |   |   |
|----------|-----|---|---|---|
| Gravida: | G 1 | P | L | A |
|----------|-----|---|---|---|

LMP: 24/12/2025 EDD: 1/7/26 Gestational Age: 37+5 weeks

|                        |                                         |                                        |                             |                                                                      |      |              |
|------------------------|-----------------------------------------|----------------------------------------|-----------------------------|----------------------------------------------------------------------|------|--------------|
| Uterine Contraction    | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Frequency:   |
| Membrane Rupture       | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Fluid Color: |
| Vaginal bleeding       | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Amount:      |
| Pre Eclampsia Symptoms | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting |      |              |
| Good fetal Movement    | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            | <input type="checkbox"/> NA | If No specify:                                                       |      |              |

5) **Pain Screening:**

**Numerical Pain Scale (NPS)**



- Location: .....
- Duration: ..... Days / Weeks/ Months (Strike out which is not applicable)
- Character: .....
- Frequency: nt
- Interventions: .....

6) **Past History:**

- a) Surgeries: nt
- b) Medical: .....





1) Allergy: ☐ Yes ☒ No, If Yes : .....

8) Current Medications: ☒ Prenatal Vitamin ☐ None ☐ Others: .....

9) Prenatal Medical History:

- ☒ None ☐ Gestational Diabetes  
☐ Chronic Hypertension ☐ Low placenta  
☐ Gestational Hypertension ☐ Others if yes, specify .....  
☐ Diabetes

**Triage Category:** (Please tick on the category)

**Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

- ☐ **Category I:** Resuscitative (Time to Physician: Immediate & Reassessment: Continuous nursing care)  
☐ **Category II:** Emergent (Time to Physician:  $\leq 15$  minutes & Reassessment: Every 15 minutes)  
☐ **Category III:** Urgent (Time to Physician:  $\leq 30$  minutes & Reassessment: Every 15 minutes)  
☒ **Category IV:** Less Urgent (Time to Physician:  $\leq 60$  minutes & Reassessment: Every 30 minutes)  
☐ **Category V:** Non Urgent (Time to Physician:  $\leq 120$  minutes & Reassessment: Every 60 minutes)

**OBCU Obstetrical Triage Acuity Scale (OTAS)**

| OTAS                       | Level 1<br>(Resuscitative)                                                                                                                                                                                         | Level 2<br>(Emergent)                                                                                                               | Level 3<br>(Urgent)                                                                                                                                                                                            | Level 4<br>(Less Urgent)                                                                                                                                                                                                                                                    | Level 5<br>(Non Urgent)                                                                                                                                                                                                                                                                                      |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Level 1<br>(Resuscitative) | Immediate                                                                                                                                                                                                          | $\leq 15$ minutes                                                                                                                   | $\leq 30$ minutes                                                                                                                                                                                              | $\leq 60$ minutes                                                                                                                                                                                                                                                           | $\leq 120$ minutes<br>(2 Hours)                                                                                                                                                                                                                                                                              |
| Re-Assessment              | Continuous Nursing Care                                                                                                                                                                                            | Every 15 Minutes                                                                                                                    | Every 15 Minutes                                                                                                                                                                                               | Every 30 Minutes                                                                                                                                                                                                                                                            | Every 60 Minutes                                                                                                                                                                                                                                                                                             |
| Labour / Fluid             | Imminent Birth                                                                                                                                                                                                     | Suspected Pre-term Labour / PPROM < 37 Weeks                                                                                        | Signs of Active Labour > 37 weeks                                                                                                                                                                              | Signs of Early Labour / SROM > 37 weeks                                                                                                                                                                                                                                     | Discomforts of Pregnancy                                                                                                                                                                                                                                                                                     |
| Bleeding                   | Active Vaginal bleeding with/ without abdominal pain                                                                                                                                                               | Bleeding associated with cramping (<spotting) <37 weeks                                                                             | Bleeding associated with cramping (>spotting) >37 weeks                                                                                                                                                        | Spotting                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                              |
| Hypertension               | Seizure activity                                                                                                                                                                                                   | Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain                                                              | Mild hypertension > 140/90 with/without associated signs and symptoms                                                                                                                                          |                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                              |
| Fetal Assessment           | Abnormal FHR tracing<br>Non-Fetal Movement                                                                                                                                                                         | Atypical FHR tracing,<br>abnormal dopplers<br>Diseased fetal movement                                                               |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                              |
| Others                     | <ul style="list-style-type: none"> <li>Acute onsite severe abdominal pain</li> <li>Altered level of consciousness</li> <li>Cord prolapse</li> <li>Severe respiratory distress</li> <li>Suspected sepsis</li> </ul> | <ul style="list-style-type: none"> <li>Major trauma</li> <li>Shortness of breath</li> <li>Unplanned and unattended birth</li> </ul> | <ul style="list-style-type: none"> <li>Abdominal/back pain greater than expected in pregnancy</li> <li>Flank pain / hematuria</li> <li>Nausea /vomiting and /or diarrhea with suspected dehydration</li> </ul> | <ul style="list-style-type: none"> <li>Ongoing assessment from out patient clinic (for hypertension, blood work)</li> <li>Minor trauma (minor MVC/fall)</li> <li>Nausea/Vomiting and /or diarrhea</li> <li>Signs of infection (ie dysuria ,cough, fever, chills)</li> </ul> | <ul style="list-style-type: none"> <li>Anything that does not seem to pose threat to mother or fetus</li> <li>Cervical ripening</li> <li>Out patient placenta previa protocols</li> <li>Pre-booked visits (ie Rh and progesterone injections, NST</li> <li>Assessment for version</li> <li>Rashes</li> </ul> |

Time seen by Doctor: 9AM

Nurse Name : Chemurkale Nurse Signature: CH

Date: 18/12/20 Time: 9AM



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 15/12/26

### Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify .....

Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☒ No if Yes specify .....

Source of Information: ☐ Patient ☒ Family ☐ Others, specify .....

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes, identify .....

Chief Complaints: Bleeding for menstrual time Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Manish

Time Notified: .....

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) .....

| Past Medical History                                                                                                                                                                                                                                           | Past Surgical History                                                                                                                                                                                                                                                                                                                                                                                                 | Previous Hospital Admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <br><br>                                                                                                                                                                                                                                                       | <br><br>                                                                                                                                                                                                                                                                                                                                                                                                              | <br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Gynecology Assessment:</b> <input type="checkbox"/> Not Applicable<br>Menstrual History: <u>Regular</u><br>Onset of Menarche: .....<br>Menstrual Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br>Last Menstrual Period: ..... | <b>Gynecology Surgical History:</b><br>Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Others: ..... | <b>Gynecological History:</b><br>Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br><b>Infertility:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br><b>If Yes Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary |

Obstetric History: G ..... P 1 ..... L ..... A .....

Previous LSCS: .....

Current Medication: ☐ None ☒ Yes, If Yes, Fill the reconciliation form

Family History: ☒ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease  
☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98 HR: 72 RR: .....  
 BP: 120/80 Weight: ..... Height: ..... BMI: .....

Pain Assessment: Pain: ☐ Yes ☒ No (If Yes, complete the Pain Assessment / Reassessment Form)



# **PHYSICAL ASSESSMENT**

**General Appearance:** ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

**Fall Assessment:** ☒ Yes ☐ No Score ..... (complete the Morse Fall Risk Assessment Sheet)

**Risk of Pressure Sore:** ☐ Yes ☐ No Score ..... (complete the Braden Q Sheet)

**FUNCTIONAL SCREENING:** If a patient needs assistance with any of the following inform consultant

- ☐ Mobility problem
 ☐ Walking Problem
 ☐ No Abnormality Detected  
☐ Developmental Delay
 ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:** ☒ No Abnormality Detected

- ☐ Overweight
 ☐ Poor Appetite > 3 Days
 ☐ Needs Therapeutic Diet.  
☐ Under Weight
 ☐ Diabetes Mellitus
 ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

- ☒ Calm & Cooperative
 ☐ Restless
 ☐ Depressed
 ☐ Agitated
 ☐ Confused  
☐ Others .....

Inform consultant for positive criteria

**SOCIAL SCREENING:**

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow

2. **Special Habits:** **Smoker:** ☐ Yes ☐ No **Alcohol Abuse:** ☐ Yes ☐ No **Drug Abuse:** ☐ Yes ☐ No

**Social History:** Lives With .....

**Orientation has been given regarding the following aspects:**

- Call Bell in Reach : ☒ Yes ☐ No
 Waste Disposal Explained: ☐ Yes ☐ No  
 Infusion Pump : ☐ Yes ☐ No
 Hand Hygiene Explained: ☐ Yes ☐ No
 ☐ Others

Above information given to .....

Name of Person Orientation was given to: .....

Orientation not given Reason: .....

Nurse Signature: 

Nurse Name: Mounika

Date & Time: 15/7/26





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## CROSS CONSULTATION FORM

Doctor Name : Dr. Swapna Date : 20/7/26 Time : 12 pm

Diagnosis : LSCS

Hospital : RCH HMNR

**Type of Referral :**

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☒ Co-Management ☐ Transfer of care

**Reason for Referral :** If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: \_\_\_\_\_

**Findings and Recommendations :**

Lactation care plan

- well formed Breast & Nipples
- Sucking observed
- Explained position & suckling.
- Aim for deep latch as demonstrated in cross
- Demand feeding not exceed 2 1/2 hours as per early  
cuddle hunger cues.
- warm care, prim's
- Advice DBF & f/b Burping.
- CobS-beam seen.

**Consultant :**

Name : Sathwik-a-g Signature : [Signature] Date & Time : 20/7/26 / 12 pm



## BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?



a. Yes



b. No

2. If No, Reason .....

3. Nipple condition:



a. Nipple well formed



b. Flat nipple



c. Inverted nipple



d. Short nipple

4. Milk flow:



a. Good



b. Drops of colostrums



c. Dry

5. Steps for Positioning and attachment: *Yes*



a. Baby goes to the breast



b. Mother always sits with a back support



c. Ear-shoulder-hip should be in a straight line



d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:  
Cross Cradle



Feeding Positions:  
Football / Clutch



6. Was the position explained:

- ☒ a. Yes  
☐ b. No

7. For Caesarian mothers:

yes

- ☐ a. Mother is required sit and feed from the 4th feed  
☐ b. Please explain football hold

8. NICU admission:

No

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date:

18/7/26

plan for vitals

plan for DBF

plan for warm care

plan for 2/0 chest

Handover given by

Anub

Handover taken by

Signature

Anub

Signature

Date & Time:

18/7/26

Date & Time:

**Rainbow Childrens Hospital-Himayatnagar**

BAH-00520821  
Mrs SHIKHA MANTRI  
27-12-1995 30 Y 6 M 21 D (F)  
Dr. SWAPNA SAMUDRALA  
IP26-00006876

inbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar, Hyderabad, Telangana, INDIA, 500029.  
TEL NO :040-48873000  
WEB : <https://rainbowhospitals.in>

**GENERAL CONSENT FOR TREATMENT**

Patient Name: Mrs SHIKHA MANTRI

Age : 30 Y 6 M 21 D

IP No: IP26-00006876

Sex: Female

Consultant: Dr. SWAPNA SAMUDRALA

Ward/Bed No: 4F -OT/LDR-415

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned do consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

**Note:**

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.  
(Receivers Signature: *Siddharth*)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

*Siddharth*Name: *Siddharth Mantri*Relationship: *Husband*

Patient Address:

H.NO: 1-10-175, STREET NO:08,  
ASHOK NAGAR, HYDERABAD Ashok  
Nagar Hyderabad INDIA 500020

Date: *18/7/26*Time: *8:35 PM*

Witness Name:

Witness Signature: *[Signature]*



# 26 - 0000214901

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: <u>Mrs. Shikha Mantoi</u>               | Age: <u>30 Yrs</u>                  | Gender: <u>Female</u>                       |              |
|-------------------------------------------------------|-------------------------------------|---------------------------------------------|--------------|
| UHID No: <u>BH-00520821</u>                           | IP No: <u>26-00006876</u>           | Date: <u>18/07/26</u> Time: <u>10:20 AM</u> |              |
| Diagnosis: <u>LSCS + Myomectomy</u> <u>word-01</u>    |                                     |                                             |              |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                             |              |
| S.No                                                  | Drug Name                           | Dosage                                      | Remarks      |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                               | <u>1 amp</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      | <u>/</u>                                    | <u>/</u>     |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG | <u>/</u>                                    | <u>/</u>     |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG | <u>/</u>                                    | <u>/</u>     |
| Doctor Name: <u>Dr. M. V. R.</u>                      |                                     | Doctor Registration No: <u>67529</u>        |              |
| Signature: <u>[Signature]</u>                         |                                     |                                             |              |

## NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006876 Date: 18/07/26

Aadhaar No. of the Patient (Optional): .....

|    |                                                                                                                                       |                                |
|----|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| 1. | Name: <u>Mrs. Shikha Mantoi</u>                                                                                                       | Remarks                        |
| 2. | Complete postal address (with contact number, if any)                                                                                 | <u>Ashok nagar, Hyderabad.</u> |
| 3. | Brief description of the illness                                                                                                      | <u>LSCS + Myomectomy</u>       |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) | <u>NO</u>                      |
| 5. | Details of essential Narcotic drug dispensed                                                                                          | <u>Fentanyl</u>                |

| Date           | Name of the Essential Narcotic Drugs | Quantity  | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
|----------------|--------------------------------------|-----------|----------------------------------------------------------------|-----------------|
| <u>18/7/26</u> | <u>Fentanyl</u>                      | <u>01</u> |                                                                |                 |
|                |                                      |           |                                                                |                 |

Dispensed by (Name & ID No.): ..... Signature: [Signature]

Received by (Name & ID No.): Sarawathi (021006) Signature: [Signature]

Time: .....



# 26 - 0000214901

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name: <u>Ms. Shikha Manta</u>                 | Age: <u>30 yrs</u>                  | Gender: <u>Female</u>                |              |
|-------------------------------------------------------|-------------------------------------|--------------------------------------|--------------|
| UHID No: <u>BH-10520821</u>                           | IP No: <u>26-00006876</u>           | Date: <u>12/01/26</u>                |              |
| Time: <u>10:20 AM</u>                                 |                                     |                                      |              |
| Diagnosis: <u>ISCs + Hypertension</u>                 |                                     |                                      |              |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                      |              |
| S.No                                                  | Drug Name                           | Dosage                               | Remarks      |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                        | <u>1 amp</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                      |              |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG | <u>/</u>                             | <u>/</u>     |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                      |              |
| Doctor Name: <u>Dr. M. R.</u>                         |                                     | Doctor Registration No: <u>67529</u> |              |
| Signature: <u>[Signature]</u>                         |                                     |                                      |              |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

#### (Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006876 Date: 12/01/26

Aadhaar No. of the Patient (Optional): .....

| 1.             | Name: <u>Ms. Shikha Manta</u>                                                                                                        | Remarks                    |                                                                |                 |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------|-----------------|
| 2.             | Complete postal address (with contact number, if any) <u>Shikha nagar, Hlyderabad.</u>                                               |                            |                                                                |                 |
| 3.             | Brief description of the illness                                                                                                     | <u>ISCs + Hypertension</u> |                                                                |                 |
| 4.             | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | <u>NO</u>                  |                                                                |                 |
| 5.             | Details of essential Narcotic drug dispensed                                                                                         | <u>Fentanyl</u>            |                                                                |                 |
| Date           | Name of the Essential Narcotic Drugs                                                                                                 | Quantity                   | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>12/1/26</u> | <u>Fentanyl</u>                                                                                                                      | <u>01</u>                  |                                                                |                 |
|                |                                                                                                                                      |                            |                                                                |                 |

Dispensed by (Name & ID No.): ..... Signature: [Signature]

Received by (Name & ID No.): [Signature] (021006) Signature: H

Time: .....





## BILLING POLICY

- **Billing cycle:** - With effective from 1<sup>st</sup> January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpain the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

## MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only ), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

*[Signature]*

Name & signature of Patient/Attendant

*[Signature]*

(Signature of Admission Desk executive)

**NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.**

## RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000